Registered at the G.P.O., Sydney, for Transmission by Post as a Newspaper. Published Weekly. Price: 1s.

THE

MEDICAL JOURNAL OF AUSTRALIA

VOL. II.—11TH YEAR. SYDNEY: SATURDAY, AUGUST 16, 1924. No. 7.

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An Address.[1]

By J. RIDDELL, M.B., B.S. (Melbourne), M.R.C.S. (England), L.R.C.P. (London).

Retiring President of the South Australian Branch of the British Medical Association.

As my period of office as President of this Branch of the British Medical Association has now drawn to a close, in accordance with the custom established early in the history of the Branch and strictly adhered to since I feel it incumbent to make some observations which may be of interest to members under the title of "A Presidential Address."

When some years ago I accepted a seat on the Council with a view to representation of rural members I had little thought that the honourable position of President of the Branch would be added to my duties. However, when accepting the position, though feeling particularly unworthy especially following so many distinguished gentlemen who had formerly presided over this Branch of the Association, I did so with the full conviction that the common interests of urban and rural practitioners would be still more reconciled and appreciated.

[1] Read at the Annual Meeting of the South Australian Branch of the British Medical Association on June 27, 1924.

The year has passed and the objects of the Branch have been so far as possible accomplished, as the volume and value of work achieved will bear witness. Regular scientific and medico-political Branch meetings have been held and widely attended and the utmost unanimity of purpose has prevailed. Yet it would appear there are some who do not realize the scope, value and diversity of activitites of our Branch established some forty-five years ago under its present name as an offspring of that Empire-wide organization originally founded in England by Sir Charles Hastings ninety-two years ago.

Prior to the formation of the Branch there existed in South Australia a medical society which would seem not to have enlisted the confidence of the then practising profession. Accordingly at a meeting held on June 19, 1879, at the South Australian Club Hotel some twenty to thirty medical men decided to form the South Australian Branch of the British Medical Association.

Of the original members present at that meeting two only survive, namely, Sir Joseph Verco and Dr. W. T. Hayward, C.M.G.. Throughout the years that have followed, these two gentlemen have been most assiduous in promoting the interests of the Branch and by high ideals in life and practice have guided practitioners old and young alike "to maintain the

honour and respectability of the medical profession whilst promoting the advancement of medical and allied sciences".

The presentation to Dr. Hayward of the gold medal of the Federal Committee of the British Medical Association in Australia which took place at the first session of the Australasian Medical Congress (British Medical Association) during the year, was a timely and worthy recognition of long and faithful service and as such the honour was well received by our members and the recipient universally congratulated.

A study of the history of this Branch since its inception forty-five years ago reveals one of steady progress. Our present membership of three hundred and twenty-three representing 95% of the whole practising profession in South Australia, denotes a body of citizens specially trained in the science and art of medicine actuated by one common desire —the relief of human suffering, the betterment of the communal health and the environment in which people live. When it was decided to form the Branch, the objects as set out in a resolution passed at the inaugural meeting were: To promote the advancement of medical and surgical science by the reading and discussion of original papers, exhibits of specimens and cases, to form a bond of union amongst the members of the profession and a medium through which their opinions could be easily ascertained and expressed and to advance the general and social interests of the profession. These objects have been and are still being attained.

Professional *esprit de corps* was never more pronounced than it is today; we note a united profession, each unit, the senior and the junior, urban and country, striving to assist each other for the advancement of medical and surgical knowledge and promotion of the common weal. But much more, the influence of the Branch has been to establish and consolidate relations of confidence between the public and the profession. During the course of a year the Council of the Branch is called upon to discuss and transact much medico-political work, the volume of which has of recent years been largely accentuated through the activities of the Federal Committee. This Committee represents all the States and has undertaken the task of consolidating the policy which affects the profession as a whole in its relationship with the Commonwealth body politic. Though the value of this medico-political work may not be immediately apparent to general practitioners, a section of whom possibly views the practice of medicine simply as a means of livelihood, it has a large influence in shaping our future destinies as medical practitioners.

During recent years we cannot fail to have witnessed a marked development in regard to the interest taken in the work of our profession by the general public. I can recall as late a period as a quarter of a century ago when general practitioners and patients alike were more concerned about cure than prevention and when causation of disease was less inquired into by the general public than at the present time. But with the universal and general progress of education and moreover the prominence given to matters medical by the lay press with some stimulus added by the professional politician the public nowadays has been caused to inquire into and appreciate medicine, especially preventive medicine in its relation to social economy and national prosperity. That an enlightened public noting the suffering and waste produced by disease should want to know the causative factors and how far they can be prevented, is but another evidence of the general interest noted in every sphere of present day scientific advancement. This public interest is to be welcomed as being for the common good and must tend to keep the general body of the profession up to the mark of efficiency and progress. With a reviewal of past history it is apparent that the art and practice of medicine has always had as its aim the relief of human ills and the development of healthy mankind.

Prior to the epoch-making discoveries of Pasteur and their application to surgery by Lord Lister the practice of medicine was largely based on clinical observations and empiricism. It has, however, been formed into a more exact science of recent years and a large army of investigators and research workers is to be found in all civilized countries deeply interested and engrossed in solving the complex problems of disease which surround human life and tend to warp and sap its vitality. The application of the discoveries from time to time made is in the hands of medical men, specialists and general practitioners alike and the public need not experience any fear that the principles evolved will not be faithfully applied, not only curatively but in the realm of prevention of human waste.

It is of interest to note that at the recent Australasian Medical Congress (British Medical Association) the keynote was preventive medicine and during the months that have since elapsed, a general appeal, notably emanating from our Branch, has been repeatedly made for cooperation and coordination between the general body of family practitioners and the public health authorities. This is an evidence of the earnestness of the medical profession and might reasonably suggest some further measure of help from the public in regard to better, more efficient and more extensive means of inquiry and investigation than are available at present.

The method of public health administration by local boards of health, as constituted oft-times with laymen who have but the merest elementary knowledge of the principles of sanitation and communicable diseases, is open to adverse criticism. In some instances owing to vested interests it is questionable whether matters pertaining to public health receive the full consideration that would appear necessary for public safety.

Altogether apart from the question of the prevention of disease in its relation to the betterment of community health as a whole, consideration from time to time has been given by various Parliamentary parties in Australia towards improving and safeguarding the conditions of life and health of a section or sections of the community. There is

hardly a civilized country today whose laws have not established some measure of protection by insurance against one or more of the great hazards which beset members of society, such as industrial accidents, illness, unemployment, old age, invalidity and death. Because it is intended to cover what is called the mass of the people and because governmental action is necessary for its initiation and operation, this type of insurance has come to be known generally as social insurance.

It had its origin in Germany some thirty-five to forty years ago and is now established in most of the European countries, Great Britain having adopted it in 1911. In Australia today we have in operation through parliamentary act some measure of protection for sections of the community against industrial accident, old age and invalidity and at the present time, as is known to you all, a Royal Commission is taking evidence with a view to reporting to Parliament as to the advisability or otherwise of introducing a system of social insurance in the Commonwealth to provide for the protection of wage earners as a class against sickness, such insurance to carry compulsion on certain individuals and the provision of medical benefits.

Sir George Knibbs in a parliamentary report published in the year 1910 states: "The fundamental doctrine underlying social insurance, a doctrine which has become concrete in Europe, is that all classes belonging to the community should be protected by the strength of the community as a whole against incidents of misfortune on the class or individual to insure the solidarity of the whole. Whatever may be our individual attitude towards this doctrine, whatever may be our opinion as to the necessity for social or national insurance in Australia, it is well to remember that of recent years with the growth of socialism there is a profoundly altered attitude of a large section of society in regard to the provision of compulsory insurance for wage earners and others against sickness and invalidity. Though the basic idea with some citizens may be the exploitation of the medical profession, I think it might reasonably be conceded that the large majority of advocates are actuated in the main with the laudable idea of general material well-being and efficiency. However, if Parliament decides to introduce a system of national insurance into Australia based on national expediency and with due regard to finance, as a medical profession we must be prepared to meet it. The question is a State one and will be decided by the State. There can be no question of professional parochialism. We must bear in mind that we are citizens first and doctors afterwards. We may hold and vote our opinions, but should national insurance become accepted on the statutes, it will be for the medical profession, not in a spirit of antagonism nor grasp-all policy, but with due regard to our dignity as medical men, the safe-guarding of our relations with the public and the maintenance of an adequate return for services rendered based on the amount and conditions of duties performed, to define our requirements on a just and equitable basis. Then by solidarity and harmonious working we must strive to obtain that which will maintain our honour and independence and will still continue to merit the good will and approbation of fellow citizens.

Reference has already been made to the medico-political activities of our Branch rendered necessary by internal exigencies and the relations of the profession to the public. It may be that within the near future we may be faced with the most momentous issue ever connected with the history of medicine in Australia and it will be well for each and all to remember that composite machinery can work smoothly only when all are determined to pull together and render every assistance with personal individual views in order that the matured opinion of the majority may be forthcoming. Then as an Association with a long push and a strong push and a push altogether we may view the future with a complacent spirit.

Ladies and Gentlemen, permit me to thank you for the forbearance you have shown during my term as your President. The honour of office I have keenly appreciated. Further, let me express my sense of gratitude to the several members of the Council including Dr. Brian Swift, the Medical Secretary, all of whom have given loyal assistance to myself and unremitting attention to the affairs of the Branch. You have in Dr. Steele Scott elected to the presidential chair for the ensuing year a medical man who is a hard worker in the interests of the Branch, a man with the ideals of the profession at heart and who I feel sure will continue to merit your respect.

SEVEN YEARS OF NATIONAL HEALTH INSURANCE IN ENGLAND:

A RETROSPECT.

ALFRED COX, M.B., B.S. (Durham),
Medical Secretary, British Medical Association, London, England.

RECENT visitors from the United States have made me aware that great interest has been shown there in the subject of National Health Insurance, and also that a good deal of the information about it so industriously supplied to the American public and medical profession is not above suspicion as to its reliability.

When the editor asked me to put on record my views, based on a close acquaintance with the movement in this country, I felt that I ought to do so, partly because the British Medical Association would wish me to do anything in my power to assist the American Medical Association, and partly because the requests for information from your side have become somewhat frequent.

Before touching on the effects of the National Health Insurance Act of 1911 and its successors,

[1] This article has been reproduced from *The Journal of the American Medical Association* (May 7, 14 and 21, 1921) with the kind permission and courtesy of the editor of that journal. The author, Dr. Alfred Cox, has suggested that the articles be reprinted and has contributed a new chapter which will be published as an *addendum*.

it may be helpful to say something first about my own competence to deal with the subject, and secondly about the state of medical practice in this country before the operation of the Act.

Before 1908, I was for sixteen years in practice in a thoroughly and almost exclusively industrial town on Tyneside, and 90 per cent. of my patients were people who are now insured persons or dependent on them. For fifteen years before leaving general practice I had taken an active interest in the organization of our profession, particularly as carried out by the British Medical Association, and had an inside knowledge of the contract practice system by means of which so many of the persons now insured then obtained their medical attendance, taking an active part in fighting the evils that were inseparable from that system. I became Deputy Medical Secretary of the British Medical Association in 1908, serving under Dr. J. Smith Whitaker until 1912, when I succeeded him as Medical Secretary on his becoming the first medical member of the National Health Insurance Commission—the body which administered National Health Insurance until it was merged, in 1918, in the Ministry of Health. I mention these personal details in order to show that though I have never been engaged in health insurance practice I have first-hand knowledge of industrial and contract practice, and have been since 1908 in a position second to none for focusing the views of the organized doctors in this country.

Contract Practice the Forerunner of National Health Insurance.

For many years, doctors in industrial and agricultural areas have recognized that there were very considerable sections of the public who would never receive (or at any rate would never pay for) their medical attendance unless some arrangement were made on a contract basis. There are very few doctors who do not think that the *ideal* arrangement is for the patient to get his attendance from the doctor of his choice and pay for it by fees varying in amount according to the status of the doctor or the means of the patient, or the custom of the district. You in America may be in a position to do this; and if so, our contract practice arrangements and our insurance act will only have a mild historical interest for you. But we, at any rate, found many years ago that a large section of the public could not pay doctors' bills without the exercise of a rigid thrift which is beyond the powers of the average individual, either in the working class or in any other class. For the destitute we had (and still have) our Poor Law system. But the people to whom I refer were not paupers, and the great bulk of them did not want charity. They wanted to pay their way. The problem was how to arrange for this. Until 1912 the problem was not dealt with nationally, nor were the various local arrangements coordinated, except in a very partial way by the friendly societies, to which I shall refer presently. Many doctors had their own "private clubs," generally collecting from their members a small weekly contribution for which the whole family was attended—3d. a week was a very usual figure. Others arranged with the management of large works and collieries for a similar weekly or fortnightly deduction from wages which also covered the attendance on the whole family. Philanthropic persons formed "Provident Dispensaries," the members of which paid periodic contributions, and the doctors on the staff for a small annual payment saw them in their homes when necessary, or at a dispensary which was similar to an out-patient department at a hospital. Sometimes the parson or the "Lady Bountiful" of a village would organize a medical club.

The most widespread contract practice arrangement was through the Friendly Societies and Trade Unions. These bodies, sometimes only local, but more generally with branches throughout the country, gave to their members certain benefits—unemployment, sickness and funeral benefits were the most usual, but medical attendance was very frequently supplied. The members of these societies paid weekly contributions. Each local branch or "Lodge" would appoint its own doctor and pay him a sum varying from 2s. 6d. to 5s. per member per annum, and for this sum the doctor undertook to give ordinary medical attendance and medicines to each member.

There were variants of the above method, but I need not go into further detail except to mention that in some parts of industrial Lancashire contract practice of the kind described never took root. Bills were sent in to the patients as in ordinary private practice and these bills were regularly collected, generally in sums of 1s. per week. The Lancashire workmen who paid under this system regarded the visit of the doctor's collector as much a matter of course as the workman in other districts regarded the deduction of his 6d. or 9d. a fortnight from his wage.

The Effect of Contract Practice on the Medical Profession.

The system just described was subject to great variations all over the country, but with few exceptions all the methods agreed in the following particulars:

(*a*) Being based originally on a charitable desire to help people who were considered to be unable to pay ordinary fees, the remuneration was always inadequate.

(*b*) Like all other work which is underpaid, it tended to be scamped. The average doctor, of course, gave his best when the patient was really ill; but much of the work was done in a perfunctory and casual way.

(*c*) The system was taken advantage of by people whose circumstances gave them no claim on a service of a semi-charitable nature. The element of charity was ignored or forgotten, and the people in question looked upon it simply as a cheap way of getting their doctor. It was the knowledge of this that made the demand for an income limit such a war-cry in the insurance act fight.

(*d*) Contract practice therefore fell into disrepute. Many of the best doctors would not touch it, and patients frequently grew dissatisfied and went off to "a private doctor," paying him fees which they could sometimes ill afford.

(*e*) The system did not pretend to cover all that a patient might need in the way of medical attendance. It only supplied the patient with ordinary attendance. For the services of a specialist or institutional treatment he

had generally to resort to a charitable institution. Sometimes he would scrape together money for a consultation, but only rarely could he afford to have operations or other special treatment on private terms.

(*f*) It had a demoralizing effect on the medical profession. Ridiculous though the remuneration was, the appointments were much sought after by men commencing practice, as a means of getting known. Some doctors specialized in club appointments; and, by getting a large number of them, not only earned aggregate sums of considerable amount but kept out inconvenient rivals. In some districts, canvassing and various kinds of subterraneous influences were used, which not only had a bad effect on the morale of the local profession but gave rise, not unnaturally, to the impression on the part of those who administered the clubs that the doctors considered the pay to be adequate.

The British Medical Association and the Reform of Contract Practice.

This question of contract practice was the main object of attention of the British Medical Association in the years 1903-1910 which followed its reorganization on modern democratic and fighting lines. Much information was collected, and great efforts were made to improve conditions in those areas where the association was strong. That there was room for improvement is shown by the following figures, the result of inquiries made by the association in 1905 as regards the remuneration received for this contract work:

Replies to inquiries were received from 1,548 doctors. The remuneration varied between 2s. and 6s. per member per annum, to include the provision of medicines. Twenty-three per cent. paid less than 4s. a year, and 23 per cent. paid 5s. and over. The great majority paid 4s. In the majority of the clubs there was no wage limit, and many cases of gross abuse by well-to-do people were given. Three hundred and ninety-three doctors answered the question as to what fee they considered would be adequate; 145 of these named 5s. per member per annum.

It must be noted that the abolition of contract practice was never contemplated as a matter of practical politics. It was always recognized that in most areas for some classes of working people contract practice was the only practical method available. The Association was in the midst of a resolute campaign to evolve some sort of order out of this chaos, and to put contract practice work on a basis that would allow of the profession regarding it, if not with satisfaction, at least without a sense of shame, when, in 1900, the Reports of the Royal Commission on the Poor Law appeared. This Commission was a very important body whose reference was to consider the whole question of the relief of distress, and naturally the provision of medical attendance, occupied a conspicuous position in their reports. There was a Majority Report and a Minority Report. These differed in the treatment proposed, but they agreed on diagnosis. Both agreed that the then existing provision of medical attendance for the working classes was thoroughly unsatisfactory. The majority recommended that it be reorganized on an insurance basis. The minority wanted medical service to be municipalized, paid for out of the rates, with the right on the part of the Local Authorities to recover the charges from those able to pay.

Immediately on the issue of these Reports, the British Medical Association began to consider them and to try to devise a scheme which should avoid the setting up of a state or municipal whole-time service, which the profession with very few exceptions strongly disliked, and still dislikes. The whole situation was, however, changed with the advent of Mr. Lloyd George's National Health Insurance Bill in 1911. He boldly adopted the principle of insurance—not voluntary but compulsory—for all manual workers whatever their income, and (with insignificant exceptions) for all other workers whose wages did not reach the then existing income tax limit of £160 a year. It is now £250.

The National Health Insurance Bill of 1911.

I will not attempt to enter into details about the struggle by which the profession, with a considerable amount of success, tried to mould the National Insurance Bill of 1911 into a measure which should be acceptable to it. The "Report for 1912-13 on the Administration of the National Insurance Act, Part I.," published by the Government in 1913 (Cd. 6907), which is a very fair and complete, though necessarily concise, statement of the position, should be studied by all who wish to know the details of the introduction of the Act, and its administration in its earlier stages. A fundamental complaint always made by the British Medical Association, on which the whole burden of the fight on the professional side fell (it cost our funds £30,000 in addition to large sums spent out of special voluntary funds, raised by the Association), is that Mr. Lloyd George, then Chancellor of the Exchequer and in charge of the bill, did not consult the representatives of the medical profession until he had laid down the main lines of the bill in consultation with the Friendly Societies and Trade Unions. It is true that the cooperation of these bodies (which under the name of "Approved Societies" administer the Sickness Benefit) was essential for the acceptance and the satisfactory working of the measure. But, although Mr. Lloyd George did not at first see it, the cooperation of the medical profession was no less necessary. It may be said without fear of contradiction that the determination the profession showed and the sympathy it was able to enlist among the public and in Parliament made it impossible for the future that any parliamentary bill of any consequence affecting the medical profession should ever be introduced without consultation with the British Medical Association.

The following demands were formulated by the Association and became known as the "Cardinal Points" of the profession:

1. An income limit of £2 a week for those entitled to medical benefit.
2. Free choice of doctor by patient, subject to consent of doctor to act.
3. Medical and maternity benefits to be administered by insurance committees and not by Friendly Societies. In connection with the question of the method of administration of medical benefit, the Representative Meeting[1] of the Association resolved that all questions of professional discipline should be decided exclusively by a body or bodies of medical practitioners, and that the power of considering all complaints against medical practitioners

[1] This body corresponds to the House of Delegates of the American Medical Association.

should be vested in a local Medical Committee, with a right of appeal to a central Medical Board to be appointed for that purpose.

4. The method of remuneration of medical practitioners adopted by each Insurance Committee to be according to the preference of the majority of the medical profession of the district of that committee.

5. Medical remuneration to be what the profession considers adequate, having due regard to the duties to be performed and other conditions of service.

After careful consideration, the representative meeting resolved that the claim of the Association should be for 8s. 6d. as a minimum capitation fee, not including extras and medicine.

6. Adequate medical representation among the insurance commissioners, in the central advisory committee, and in the insurance committees, and statutory recognition of a local medical committee representative of the profession in the district of each insurance committee.

1. *The Income Limit.*—This was fought strenuously, but was from the first denied by the Government, whose action was endorsed by large majorities in Parliament. We were always told that it was administratively impossible: that the wages of manual workers varied so much that if an income limit were fixed very large numbers would be constantly "in and out," and that no effective insurance scheme could be worked on such a basis. A concession was made (on paper) in the later stages of the bill, and the Insurance Committees (which administer Medical Benefit) were empowered to fix a *local* income limit. This has been a dead letter.

2. *Free Choice of Doctor by Patient and Vice Versa.*—This was gained. Patients choose any doctor they like on the local list and have the right of changing, without consent of the doctor, twice a year. A change can be effected at any time by mutual consent.

3. *Medical and Maternity Benefits to be Administered by Insurance Committees and not by Approved Societies.*—This was gained, so far as medical benefit is concerned. Maternity Benefit is merely a cash payment, and the medical profession, as soon as it realized this, did not press the point. The profession was determined, after its experience of club practice, that it would not put itself under the control of the Approved Societies or any similar bodies, though it had no objection to the control of a public body on which the profession, as well as the Approved Societies, were represented. Complaints against doctors are decided, not by an exclusively professional body as demanded in the Cardinal Point, but by a body composed half of doctors and half of representatives of Approved Societies, with an independent Chairman appointed by the Insurance Committee. The plan works very well, and there are practically no complaints about it.

4. *Method of Remuneration to be as Decided by the Profession Locally.*—This was gained. In every Insurance area in the country except two (Manchester and Salford), the capitation system was chosen. The two areas named work on a payment per attendance basis, but it must be remembered that, whatever the method chosen, the amount to be distributed locally is allocated from a Central Pool and is in proportion to the number of insured persons in the area. Therefore, the profession as a whole in any area gets the same total remuneration whether they are paid by one method or by the other.

5. *The Amount of Remuneration.*—This has never yet been considered adequate. The original amount offered was 6s. a head, to include drugs. Before the Act came into operation this was increased to 9s. a head, to include provision of drugs. Of this the doctor who did not provide drugs received 7s., with a chance of getting anything up to another 6d. if the chemists' call on the drug fund proved to be more than 1s. 6d. but less than 2s. The amount now (since January, 1920) is 11s. a head for medical attendance alone, and the State takes full responsibility for the drug bills. The doctors who attend persons not within reach of a chemist provide the drugs and get for this service 2s. a head of all those on their dispensing list.

6. *Representation of Profession on Various Administrative Bodies: Statutory Recognition of Local Medical Committee.*—The representation of the profession on the Insurance Committees has never been considered to be adequate, though less is heard about the point now than formerly, because more and more responsibility in purely professional matters is being placed on the Local Medical Committee and the Panel Committee, of which more later. A medical representative was placed on the commissioners who administered the Act centrally, and full representation was given to the profession on an Advisory Committee set up to be consulted by the commissioners in questions about regulations.

It is interesting to note, in connection with the question of remuneration, that the Government in 1912, before the Act came into operation, with the agreement of the Association made an inquiry in five selected towns to ascertain what was the annual cost of medical attendance and drugs per head of the population, including rich and poor and both private and contract practice. The inquiry was conducted by an eminent accountant, agreed upon by both parties, and the result showed that the cost per head (excluding operations and institutional treatment) was 4s. 5d. a year. The Association did not accept all the conclusions which the Government drew from this inquiry, but the figures undoubtedly made a considerable impression both on the public and the profession.

THE ACT GOES INTO EFFECT.

The Medical Benefit of the Act came into force January 15, 1913, and up to the last moment the profession declared itself unwilling to accept the terms offered. The temper of the profession was thoroughly roused, and feeling ran exceedingly high. Largely attended meetings of doctors were held all over the country at which votes were taken which showed almost everywhere a large majority against accepting service. At a meeting, December 21, 1912, of the Representative Body of the Association, at which representatives from every part of the country attended, it was decided by a large majority to refuse the final offer of the Government. Shortly after that date, however, a "rot" set in, and on

January 3 the Government announced that over 10,000 doctors had accepted.

Lessons to be Drawn from the Fight.

It would serve no good purpose now to enter closely into the history of that struggle, but it is only fair to the British profession that I should set down a few of the extenuating circumstances which ought to be taken into consideration and some of the lessons which, looking back on the whole business, I think can fairly be drawn.

First, we had no experience to guide us as to what the effects on the profession of such a national system were likely to be, and, like everybody else, we dreaded the unknown. The German experience was not of much use. Our system is very different from the German system in almost every particular.

Secondly, there was a good deal of political feeling mixed up with the whole affair. I am afraid that this is inseparable from the introduction of any such system. I do not mean to suggest that the great majority of the profession were consciously affected by party considerations. But Mr. Lloyd George's position in the country was very different then from what it is now. He was then the demagogue of the advanced Radicals and had made himself very objectionable to all persons of a conservative tendency, of whom there is a fair share in the medical profession. Party politics at that particular time were perhaps as strongly held and were as strongly in evidence as at any time in the history of this country.

Thirdly, although we did our best to secure the opinion and test the trustworthiness of every member of the medical profession, there was always a considerable section who would attend no meetings and give no pledges. At the end, the attitude of these men was the subject of much suspicion on the part of the others, and an exaggerated idea of what a few men could do in the way of "collaring" the work led the weaker brethren to stampede. This tendency was greatly increased by the action of the Government, who made it known that they had an army (it must have been a *very* small one) of men who were prepared to work the system anywhere. It is quite certain that if this had been the only weapon of the Government, they could have been beaten easily had the profession felt the final offer to be so bad that it must be resisted at all hazards. The strongest weapon of the Government was that the increased money offer and the alterations that the profession had secured in the bill had gradually led many doctors to the belief that the new system would pay them. Men who had, more or less willingly, been doing a large amount of contract practice at 3s. 6d. a head came to the conclusion that double that amount made it well worth while to accept the new service.

Fourthly, we had had no experience of fighting a Government. In the earlier stages many doctors under-estimated the magnitude of the task; later they unduly exaggerated it. The Government (after the Act had been passed and before it came into operation) astutely fostered the idea that the profession was attempting to upset the decisions of Parliament, and gained the sympathy of many of the public who had hitherto regarded the profession with the admiration the British public always shows for a good fighter. The British public loathe "direct action" because it is unconstitutional and even more because it is unsportsmanlike. They hold that when the decision of Parliament goes against you it is your business to try to alter the composition of Parliament or the opinion of the majority but not to refuse to accept its decision. It is impossible to exaggerate the importance of carrying public sympathy in such a fight. We had it with us all the time we were fighting for "free choice of doctor," adequate remuneration, and a reasonable voice in the way the professional side of the Act was to be worked. We lost much of it when people began to think that we were irreconcilable and unconstitutional.

Finally, we had really done very well. No unprejudiced man now looking back at the bill as introduced and comparing it with the Act as it passed could fail to see that our fight had greatly improved our position. The attitude of a considerable section of the public was well voiced by the *Westminster Gazette*, which said, apropos of a demonstration of disappointed doctors: "We all admire a man who does not know when he is beaten. The trouble about B.M.A. is that it does not know when it has won."

Outline of System as at Present Constituted.

I come now to the present position. The Insurance Act of 1911 has been modified in important respects by subsequent Acts, but the plan of the medical service remains essentially the same. The Insurance Commissioners first appointed to administer the Act centrally have been merged in the Ministry of Health, and the efforts of the Ministry are being directed to the coordination of the medical attendance on insured persons with the various other forms of medical service, domiciliary, preventive and institutional.

The National Health Insurance Service is regulated by the various Acts, supplemented as regards details by Regulations made by the Ministry which have all the force of an Act of Parliament while they exist, though they can be altered much more easily. The service is administered locally by Insurance Committees, of which there is one in every County and County Borough, 200 in all in England, Scotland and Wales. There is no medical benefit in Ireland, and what I have to say does not apply to that country, where conditions economically, socially and medically, differ materially from those on this side of the Irish Channel. Irish insured persons receive sick benefit when they are ill, but their medical attendance is not provided by the Insurance Committees. The contributions of Irish insured persons are therefore less than those in Great Britain.

The Insurance Committees adminster Medical Benefit; that is, they are responsible for the provision of medical attendance for every insured per-

son in their area. The Approved Societies (the old Friendly Societies, some of the Trade Unions, and some other societies which are branches of the big Industrial Insurance Companies) administer Sickness Benefit and Maternity Benefit. That is, they distribute the appropriate sums of money to insured persons who are sick, and to the insured women and the wives of insured men when they are confined.

Every doctor on the British Register has a statutory right to be on the list of doctors for the insurance area or areas in which he or she practises, and he can only be removed from that list at his own wish or after an inquiry in which he is proved to the satisfaction of the Minister of Health to be unfit to be on that list. I will deal with the question of disciplinary inquiries separately. There are in England, Scotland and Wales 33,304 doctors on the Register, all of whom have a right to do National Insurance work. But you must exclude all the doctors who are not in general practice, as well as the considerable number who do not practise among the industrial classes. Probably 24,000 are in general practice. Of these there are 12,850 actually doing National Insurance work (December, 1920). In the industrial and rural areas the great majority of the doctors are insurance practitioners. In many areas every doctor is so acting. In the towns with a more residential population, such as seaside and pleasure resorts, the proportion of doctors not doing this work is naturally greater. There is a considerable number of doctors who, though general practitioners in industrial areas, have always declined to take part in the service, and many of these are associated in the National Medical Union, to which the Insurance service has always been anathema. Its membership is probably well under 1,000, though no recent figures are available. Some doctors have refused to take part in the service because of a rooted disbelief in any form of contract practice, some because they took part in the fight against the Insurance Act and still object to it, some because the quality of their practice is such that they think they do better by declining to accept insured persons, as such, as patients.

The number of insured persons in Great Britain is approximately 12,500,000, so that the average number of insured persons in the care of one doctor is under 1,000. The list or "panels" vary from one to two hundred to between 4,000 and 5,000; but these very big lists are *very* exceptional and will soon be unknown, as by the latest regulations no doctor, unassisted, may have more than 3,000 on his list (in some areas less, for there is local option as to the maximum number so long as it is not above 3,000). Doctors who last year had more than the maximum for their area have been given a year during which they may either reduce their lists, or take a partner or assistant.

RANGE OF SERVICE.

The agreement of the doctor is to give such service "as can properly be undertaken by general practitioners of ordinary competence and skill." This restriction has given rise to much criticism, most of it based on ignorance of the history of the service. When Mr. Lloyd George introduced his bill, the British Medical Association pointed out to him that the service he was offering was incomplete: that without the services of specialists and consultants many of the insured persons would be getting no more than they could get for themselves without the new service; that the doctor would often be unable to do his duty fully by the patient in the absence of a second opinion and the services of specialists; that without institutional facilities the service was badly handicapped, as the insured persons would still in the future as in the past have to depend mainly on charity, and that no provision whatever was made for the dependants, who were just as unable as the insured persons to provide domiciliary attendance for themselves. Mr. Lloyd George admitted all this and said he would be delighted to make the service a complete one, but that the country could not or would not afford it; that he wanted to make a beginning with the thing that he believed was the basis of any such service, namely, domiciliary attendance; that the rest could be added in the future, and that the experience gained by the present service would be of great value in deciding when and how best to expand it. The British National Health Insurance system is open to many criticisms, some of which, from the doctor's point of view, I shall mention; but it is not fair to blame it for being what it never pretended to be. It gave some of the insured persons a service they had been providing for themselves privately; it gave a large number a service they had never been able to get before except partially and occasionally through charity; it gave a much larger number a service similar to, though better than, what they had been getting on a contract basis. But it did not pretend to give any of these classes a complete medical service.

From the beginning of the Act, the medical profession has never ceased to ask for the addition of the things that are lacking and in 1914, just before the war, the Government voted money to set up a service of official Medical Referees (to settle disputed cases of ability to work), and to provide (*a*) second medical or surgical opinions; (*b*) a nursing service, and (*c*) laboratory facilities. The war stopped these extensions, but we have now (end of 1920) the official Referees, who will be able to command a second opinion when they think fit. Other extensions are under consideration at the Ministry of Health, but their provision seems likely to be retarded by the inability of the country to find money for anything that can be postponed—an inability shared, I believe, by every other lately belligerent country except the United States.

CONTROL OF THE SERVICE.

General.—The Ministry of Health makes the Regulations which (subject to the provisions of the various National Insurance Acts) govern the service and are in operation in the area of every Insurance Committee. These Regulations are of the greatest importance, both to the insured person and to the insurance practitioner. They lay down, *inter*

alia, the way in which the insured person may choose his doctor (any doctor on the list); the times at which he can change (twice a year without the consent of the doctor, any time with it); the hours at which the doctor can be seen (this is subject to local agreement and varies considerably from area to area and even from doctor to doctor); the method by which the patient gets his medicines (from the chemist if one is reasonably available, from the doctor if there is no chemist, as in many rural areas); the way in which and the times at which the doctor is paid (usually quarterly); the rules by which the patient is bound in his relations with the doctor, the way in which he can lay a complaint against his doctor, or the doctor against him; the way in which an Insurance Committee can proceed to get a doctor removed from the list if they think such a course necessary, etc.

Central.—The mere existence of regulations has been for the medical profession a new and most trying experience. I suppose the thing which most appeals to a man entering our profession is the individualism of it—the free relationship between himself and his patient; the fact that if either is not satisfied, he can go his way without any ceremony. But a contract, and especially a contract in which a third and even a fourth party (in this case the employer and the Government) are finding part of the money, in addition to the patient, necessitates rules and regulations. "The price of freedom (even comparative freedom) is eternal vigilance," and the formulation of these regulations and the constant changes that have taken place in them as the result of experience have needed the exercise of the strongest vigilance and determination on the part of our Association.

Its Effect on the Influence of the British Medical Association.

The introduction of the Insurance system has more than doubled the work and responsibilities of the British Medical Association. It is only fair to say that since we forced ourselves on the attention of the Government at the introduction of the first bill, they have never, with one small exception (not worth mentioning except to show that without constant vigilance there would have been more instances), denied the right of our organization to be consulted in the framing or alteration of regulations. It is one of the normal duties of the Insurance Acts Committee of our Association to meet the representatives of the Ministry round a table for this purpose. In the extensive revision of regulations which followed the Armistice, we met thus in Conference no less than twenty-three times. When we had roughed out the main lines on which the changes were to be founded, we circularized every insurance practitioner in the country, telling him the result of our labors. Then we had a Conference of representatives which discussed the proposals thoroughly. Then we went back to the Ministry, had more discussions, and finally the Ministry embodied the changes in actual draft regulations which we put up to another Conference. Now I do not say that the ultimate result was that we got *all* we asked for, or secured the elimination of *all* we objected to, or for the agreement of *all* our constituents. It did not. But I am prepared to say that we succeeded in getting inserted in the new Regulations a good deal of what we wanted, and eliminated many things to which we objected, and that the Regulations as they finally emerged were a very creditable production of collective bargaining, that is, of that process of give and take which is the normal way of doing business between bodies meeting as equals.

And when I say "meeting as equals," I mean it. It is true that a government department holds a very strong position. It has all the force of the government behind it and it holds the purse. But the medical profession also holds a very strong position. Without it, no service can be provided and the government is *bound* to provide a service. Even if the profession is not strong or united enough to refuse service, the heads of a government department know that a dissatisfied service is a bad service, and that a bad service has a knack of proving very awkward for the politicians and is just as awkward for the people who serve the politicians. Moreover, civil servants are reasonable persons who have a pride in the success of their department. A dissatisfied service means constant friction and more work for them. Therefore, they are prepared to go a long way to meet the responsible negotiators for the profession, who are, presumably, also reasonable persons, as equals. I make these remarks not because the American profession is necessarily directly interested in the subject, but in order to encourage those who may be pessimistic about the capacity of the profession to hold its own with State departments. The constant struggle to hold our own with politicians and Government departments has in ten years made our Association into a much more alert, active and powerful body than we could have become in several generations of more peaceful existence.

Local.—The Regulations are administered locally by the Insurance Committee, which is composed, taking one of the larger bodies say of a County, of sixty persons. Twelve of these are elected by the County Council, of whom two must be doctors; thirty-six are representatives of the insured persons; ten are nominated by the Ministry of Health, of whom at least one must be a doctor, and two are nominated by the Panel Committee, both being doctors. Thus, out of sixty members there must be at least five doctors and there may be one or two more.

The Insurance Committees vary considerably in weight and capacity. The weak spot is the insured persons' representatives, who are generally officials of the Approved Societies, and whose method of election is frequently by no means ideal from the representative point of view, owing to great differences in the constitution of the Approved Societies into which I need not enter. The Insurance Committees are not bodies whose composition could be recommended to other countries proposing to set up similar bodies. Nobody in this country believes them to be a permanent institution; but they have

done much good work under great difficulties, and we have no reason to be ashamed of them.

The Insurance Committee distributes the money (sent to them by the Ministry of Health from the Central Fund) to the doctors in accordance with the numbers of persons on their lists. It is responsible for the adequacy of the local service both of doctors and of chemists. It is responsible for the administration of sanatorium benefit for tuberculous persons, though often sharing this with the County Council or County Borough Council, to whose hands it will shortly go altogether. It has nothing to do with the administration of sickness or maternity benefits, money payments which are the province of the Approved Societies.

Each Insurance Committee must have a Medical Services Subcommittee composed of an equal number of representatives of doctors and of insured persons, with a Chairman who must be a member of the Insurance Committee, but must not be either a doctor or an insured person's representative. To this Subcommittee are automatically referred all complaints by patients against doctors and by doctors against patients. The report of the Subcommittee must go to the full Committee, but it is very rarely that the report is not accepted, frequently without discussion. It is surprising how little these Subcommittees have had to do. I believe it is a fact that even after seven years there are one or two of them which have never had a case before them, and in most areas the great majority of the complaints have been trivial. One reason for this is that the Chairman of the Subcommittee and the Clerk of the Insurance Committee, if reasonable and tactful persons, as they generally are, can usually settle cases "out of court." It is a fact, not foreseen by many of us in the earlier days, when we viewed the setting up of these bodies with great suspicion, that the medical members of the Subcommittee are notoriously much harder on medical delinquents than the lay members are. The penalties on the doctor are prescribed by the Insurance Committee on the recommendation of the Medical Services Subcommittee, and they may vary from censure to the recommendation to the Minister of Health that a part of his capitation grant be withheld as a punishment, or that he be removed from the list. The doctor has the right of appeal to the Minister. In any case of suggested removal from the list the case must be heard by an independent lawyer and two non-official doctors appointed as a court by the Minister. They report their finding to the Minister, whose decision is final. There is a fairly strong section of the profession which is very anxious that there should be a right of appeal from the Minister to a Court of Law; but up to the present the Government has always resisted this claim. One reason which has prevented many doctors from pressing this claim very strongly is the fact that such a right of appeal would of course have to be extended also to insured persons who were not satisfied, and the prospect of litigation of this kind is not very attractive. The number of doctors actually struck off the list is very small, and there has been no case in which the penalty has not been felt by all who knew the circumstances to be deserved.

The original 1911 Act recognized a Local Medical Committee in every Insurance area where the profession cared to elect one. The only condition laid down about its composition was that the Insurance Commissioners should be satisfied that it was a representative of the qualified medical practitioners of the area, after passing which test it must be consulted by the Insurance Committee on all general questions affecting the administration of medical benefit, and the arrangements made with the medical practitioners.

In some areas the doctors did not elect Local Medical Committees; and as some such committee was essential, the Act of 1913 provided that this local consultation must take place through a Committee (called the Panel Committee) appointed by practitioners who are actually doing insurance work and elected in accordance with regulations made by the Insurance Commissioners. Both the Local Medical Committee provided under the 1911 Act and the Panel Committee set up under the 1913 Act are in existence still; but in every area the personnel is the same, and for all the practical purposes of these remarks it may be taken that the Panel Committee is the body which directly represents the interests of the insurance practitioners in every area.

One of the striking features of our system is the rapid growth of the responsibilities demanded by and given to these bodies. These committees were one of the earliest, as they are one of the most outstanding examples, of the application of the modern idea of "giving the worker a share in the government of the industry in which he is employed."

There is a considerable amount of elasticity as to the methods by which the Panel Committee is elected. The only rôle of the Ministry of Health (*vice* the Insurance Commissioners) is to satisfy itself that, when elected, the Panel Committee may be taken as representative of the insurance practitioners in the area. It may be elected by postal vote or by meetings, and up to the present all Committees have been elected annually. I am sorry to say that doctors, like every other class in this country, are slack about electing their representatives, and there are few areas in which any enthusiasm is shown in the elections. There are, I am thankful to say, signs of more activity both in general and in medical politics. The war has not exhausted all our fighting spirit.

DUTIES OF THE LOCAL MEDICAL AND PANEL COMMITTEE.

It must be consulted by the Insurance Committee, *inter alia*:

(*a*) In the preparation of the local terms of service: The Insurance Committee in submitting the proposed local agreement to the Ministry for its approval must transmit any observations made by the Panel Committee; (but the *general* terms of service are settled centrally by negotiation between the Insurance Acts Committee of the British Medical Association and the Ministry of Health. The local negotiations are on local and comparatively small variations).

(*b*) On the methods of distribution of the money allocated to the area from the Central Pool, and also the money allotted from the Central Mileage Fund.

(*c*) On the rules governing the procedure of the Medical Services Subcommittee (for the purpose of hearing complaints).

(*d*) The Local Medical Committee (representing the opinion of the profession as a whole, whereas, the Panel Committee represents more particularly the doctors actually in the service—in practice the difference is negligible) must have referred to it any question which arises as to whether any given service comes within the scope of the agreement; that is, whether or no it can be said to be a service which, "consistently with the best interests of the patient, could properly be undertaken by a general practitioner of ordinary professional competence and skill." The opinion of the Local Medical Committee is usually accepted by the Insurance Committee; but when it is not, the question is referred to a court of Referees appointed by the Minister (a lawyer and two doctors appointed *ad hoc* for that case), whose decision is final. The Ministry may refer the point to Referees, even though the Local Medical Committee and the Insurance Committee are in agreement; but this is very rarely done.

(*e*) The Local Medical Committee must have referred to it any complaint made to the Insurance Committee by one insurance practitioner against another involving any question of the efficiency of the medical service, and the Local Medical Committee may make representations (and sometimes has done so) to the Minister that the continuance on the medical list of a practitioner against whom complaint is made will be prejudicial to the efficiency of the service.

(*f*) The Panel Committee must be consulted by the Insurance Committee in the preparation of the local rules regulating the administration of medical benefit, including those governing the behaviour of patients under treatment.

There are many other points in connection with the service about which the Panel Committee must be consulted, and it may be said that the Committees, when energetic and vigilant, as they often are, can and do exercise a great influence over the Insurance Committees in all the details of medical administration.

It is the duty of the Panel Committee to investigate all complaints as to alleged excessive prescribing. This is a matter which has given rise to a good deal of discussion and misunderstanding, so it must be explained at some length. When the remuneration for the service was fixed at 9s. a head, 7s. of this was definitely allocated to the doctor for medical attendance, 1s. 6d. a head to form a pool out of which the chemists were to be paid for providing and dispensing the medicines and appliances, and 6d. was kept in suspense. The 6d. was known as the "floating sixpence," and was a most ingenious device for the protection of the Drug Fund. The Government believed that 1s. 6d. or thereabouts was sufficient for the drugs and appliances, and it was not prepared to pay more than 2s. If the expenses of drugs came to more than 2s. a head in any area, then the bills of the chemists were to be discounted down to the 2s. limit. But the Government recognized that much discounting would lead to discontent among the chemists, as indeed it did, and they sought the services of the doctors in keeping down unnecessary prescribing and the consequent undue cost of drugs. They therefore promised the doctors that if they kept down the prescribing in their area to a sum between 1s. 6d. and 2s., the doctors among them would share that part of the "floating sixpence" which remained. The 1s. 6d. went to the Drug Fund anyhow, so that there was no inducement to the doctor to reduce his prescribing below that limit; but he was made a partner in the attempt to keep the cost under 2s. In very many areas the doctors got the 6d. or part of it, and only in comparatively few were the chemists' bills discounted. But the scheme, though ingenious, was objectionable. It gave rise to the suspicion that the patients were being deprived of drugs they ought to have, in order that the doctor might get the 6d. The chemists did not like it, nor did the doctors, because although it benefited them financially it exposed them to injurious suspicions. The system has been abolished—except in Scotland, where in a modified form it still remains for the present, though not, I believe, for long. The Treasury now takes full responsibility for the payment of the chemists' bills, and there is no "floating sixpence"; but the Panel Committees continue to fulfil the function imposed on them under the old system. They still have the responsibility of protecting the Drug Fund against extravagant prescribing. They have provided for them by the Insurance Committees abstracts of the claims on the local Drug Fund, and it is their duty on observing what they think to be extravagant claims to investigate them. This necessitates the examination of selected prescription forms and the interviewing of the doctors who *prima facie* seem to be ordering drugs either in excessive quantity, or of a quality or kind which seems unnecessary. There is no gainsaying the fact that this duty is not a popular one with the Panel Committees—duties are seldom popular. But the inquiries are carried out by people who *know*: doctors elected by the insurance practitioners of the area, men who are doing the same work themselves—men who know what a fair average is and who are actuated by a desire for the welfare of the service in which all concerned are employed. The accused is "tried by his peers." A doctor who can show just cause for an apparently extravagant prescription or series of prescriptions need fear nothing. The doctor who, from sheer carelessness or want of experience in prescribing, orders fancy preparations or unnecessarily large quantities will be given good advice in the first place, but if he persists will be docked (by the Insurance Committee on the advice of the Panel Committee) of the difference between what his prescriptions have cost and what the Panel Committee estimates the necessary drugs, etc., would have cost. The practitioner has a right of appeal to the Ministry. It is on the administrative machinery that I have just described that the opponents of the system have founded their complaints that the insurance practitioner is not allowed to prescribe what he thinks is best for his patients: that if he prescribes for them just as he would for a private patient he will find himself hauled before the Panel Committee and fined. I do not believe that any Panel Committee ever has or ever will penalize a doctor for prescribing any medicines, however expensive, that the doctors composing that Committee think to be necessary after full consideration and debate with the prescriber (if he cares to be present, as he always has the chance of being). I am bound to

say that the reports I have seen of some of these inquiries by Panel Committees show a recklessness on the part of a small number of doctors which is rightly regarded and punished as a waste of public money. The steady and regular investigation by the Panel Committee of the prescribing in each Insurance area is having the effect of teaching that simplicity in prescribing is not incompatible with effective treatment. I do not believe the procedure has deprived or will deprive a single insured person of any drugs really necessary for his treatment. But the system evidently does not favor "elegant pharmacy" or luxury in prescribing.

Other duties have recently been placed on the medical profession, which are exercised through an Allocation Subcommittee, composed of equal numbers of persons appointed by the Insurance Committee and by the Panel Committee. The duties of this body are to see that all insured persons get the medical benefit to which they are entitled, if necessary by allocating them to one of the doctors on the list. There are many insured persons who, in spite of repeated reminders, will not choose a doctor. This Subcommittee may, after due notice, proceed to allocate them to some doctor or doctors (this power has not yet been exercised). Sometimes a doctor or doctors will decline to accept a certain person for reasons which seem good to them, and the Allocation Subcommittee may have to allocate him to another, or even to one of those who has refused. But this is very rare. Allocation is not often required except for strangers who have come to the district and find some difficulty in getting accepted. This kind of allocation, however, is generally done, not by a meeting of the Subcommittee but by the operation of a previously arranged scheme, or by arrangements made by the Clerk of the Insurance Committee with some conveniently situated doctor. The chief duty of the Subcommittee (which only come into existence in 1920) is to allocate those persons who have been on the list of a retired or deceased doctor, and who, after due notice, do not choose a doctor for themselves. When a doctor dies or gives up practice his patients are notified by the Insurance Committee and given three months in which to select a new doctor. At the end of the three months those who have not chosen are told that unless they choose they will at the end of another month have a doctor chosen for them. During this four months the successor of the retiring or deceased doctor can be getting introduced to the practice; and though there has been little experience yet, it is almost certain that those patients of the old practice who have not selected a doctor at the end of four months will almost invariably be allotted to the successor by the Allocation Committee. It will be the line of least resistance and will naturally be favored by the medical members of the Committee who will themselves die or retire some day.

Questions Concerning the Effect of the System.

Having now given a sketch of the difficulties surrounding the introduction of the system, and a slight and rather desultory account of how the medical part of the system is worked, I will pass on to a consideration of the points to which I have been asked to devote special attention, so far as they have not already been dealt with.

1. *What effect has the system had on the practice of the average physician: has it increased or decreased the amount of his professional work?*

If by the average physician is meant the average doctor in an industrial area who has accepted service under the Act, I should say it has increased his work, more particularly the work at his surgery (or office, as I believe you call it). Persons who formerly did not go to the doctor until they were really ill now go for more trifling ailments. They go to him for complaints which formerly were either left untreated or were prescribed for by the chemist. These consultations are encouraged by the far-seeing doctor, who realizes that under a capitation system it pays him to get the patient early. The doctor also has more clerical work to do. The insured patient requires certificates in a form prescribed by the Ministry, and there are records that must be kept and communications of various kinds with the Insurance Committee. Most doctors dislike this clerical work intensely, but some of it is probably having a useful disciplinary effect on many doctors who were very unbusinesslike in their practices and kept no records of their cases. The younger generation will take to it more kindly, but there is no doubt that up to the present time the clerical duties inseparable from any State service have been a great bugbear to the profession.

2. *What effect has the system had on the income of the average physician?*

It has undoubtedly increased the income of the profession as a whole, and especially of those doctors who practise in industrial areas and who formerly did underpaid contract practice (a very large number). Some doctors who formerly made a fair amount of money from the domestic servants of their better class patients complain that they have lost money, because the capitation fees paid on account of servants who are now insured persons are less than the money they used to get in bills from this class, or rather from their employers. I doubt very much that the system has diminished the income of a single doctor in this country. Those who were in industrial areas, and who declined to accept service under the system and have continued to decline, undoubtedly lost money at the beginning, but my belief is that even these doctors have recovered their position. There is and always will be a section of the public who do not believe that they will get effective service unles they pay for it at the time or by a bill. They do not realize, any more than many doctors yet realize, that capitation fees received from a considerable number, many of whom do not require attendance during any given year, may on the year prove to pay the doctor quite as well as the fee system. A certain, or rather an uncertain, proportion of insured persons, though entitled to the services of a

doctor on the panel, go to a private doctor and pay him. This number is most areas is, I believe, comparatively small, particularly where all or nearly all the doctors are insurance practitioners. It is larger in those towns, comparatively few, where a sort of class distinction among the doctors was caused by the split over the Insurance Act and where the idea that the "panel doctor" is an inferior order of practitioner has been fostered. It is necessary to speak plainly on this subject. In the bitterness of spirit caused by the reaction in 1913 when some thousands of doctors who had been "swearing they would ne'er consent, consented" to take service, many things were said which would have been much better left unsaid. The service was declared to be "derogatory"—though nearly 13,000 doctors are working it—a most damaging admission often quoted against them. The "yellow press" sedulously quoted every attack on the system, especially when it came from a doctor. Many such attacks were made and are indeed still made, but mainly by men (some of them eminent in the profession) who have never done any industrial practice and do not understand it. The result is that the system is still talked about by some as if it were a very cheap and inferior service, given by unwilling and badly paid doctors to persons who get it as a kind of charity. This kind of thing has rebounded with great severity on the medical profession. It gives a handle still to our "yellow press" and to persons like your Mr. ————, who came over here with the intention of finding out what a bad service it is and had no difficulty in finding plenty of people to fill him up with the kind of thing he was looking for. Let it be clearly understood that there is no charity about this service.

The doctors who are doing National Insurance work in the industrial areas have undoubtedly had their incomes increased. The doctors in the rural areas have also had their incomes raised, first because they are now paid a comparatively respectable capitation fee for many people they formerly attended for nothing or for a wretched club fee; secondly, they have recently gained a good deal in payment for mileage, of which more anon. But the country doctor has not gained as much by the Insurance system as the town doctor, simply because the latter has the chance of a much bigger list.

The doctor in this country is feeling the pinch of present conditions—heavy taxation and inflated prices—as is every other middle class and professional man. But, leaving on one side war conditions, I am bound to say that financially the Insurance Act has been a blessing to the medical profession, who badly needed the stimulus it gave. It practically doubled the amount they were getting from all the people who were formerly attended on a contract basis, which I believe more than compensated for the fact that a smaller number of people who formerly paid bills and paid them well and regularly are now insured persons. The increased income gained from this class and, still more, the certainty and regularity of this income, has had a marked reflex effect no private fees and the remuneration for all other forms of contract medical work. Many a doctor who does no insurance work is today getting better fees for the work he does, simply because the Insurance Act has raised the standard for all medical remuneration.

(To be continued.)

Reviews.

RADIUM THERAPY.

In 1917 there was published from the Memorial Hospital a report of experiences in the treatment of new growths by radium. A further report has now been issued detailing experiences up to 1923.[1] The volume is a compilation by several contributors.

The technical principles employed are described by Janeway and show an increase in the extent to which radium "seeds" have been used for embedding in the new growths. Bagg showed that emanation tubes containing any quantity between 0.1 and 5 millicuries all produced a necrotic area about one centimetre in diameter so that no tubes of a greater strength than these were used; the size of the growth determining the number and emanation content of the "seeds." Quick, in discussing malignant tumours of the intra-oral group, concludes that the primary epithelioma of the lip should be managed entirely by the use of radium and the cervical glandular area should be irradiated unless glands appear. In this case unilateral neck dissection together with radium "seeds" in the wound should be employed. Cancer of the tongue should be treated similarly. For tonsillar growths the radium treatment is so rapidly efficacious that surgery should not be employed, but the results in these conditions are usually unsatisfactory on account of the early and widespread dissemination. He warns against extensive, hopeless surgery and strongly commends extensive radiation together with the use of conservative surgery under local anæsthesia for practically all this group. Rectal carcinomata in some cases manifest complete regression; considerable palliation occurs in patients with advanced growth and very advanced growths do not respond at all.

In cancer of the female genital organs the operable and border-line conditions give figures which are remarkable and indicative since careful measurements of dosage and the use of the latest type of radium "bomb" have been practised. Bayley and Quimby conclude that their results cannot be duplicated without the use of massive doses of radium or thorough radiation of the parametrium.

Burton Lee states that patients with carcinoma of the breast show a remarkable increase in their expectation of life when pre- and post-operative radiation has been practised and in many instances of primary inoperable carcinomata of the breast good results have been achieved by radiation.

The results of radium treatment of the prostate at the hands of Barringer are superior to operative removal both in regard to regression of the disease and in coping with urinary retention. Radium treatment of carcinoma of the bladder in some instances has caused complete regression.

PRACTICAL PATHOLOGY.

In "Aids to Practical Pathology" a large amount of useful data is supplied in a book which is carefully indexed and of a size easy to handle.[2] The information

[1] "Radium Report of the Memorial Hospital, New York," by Various Contributors (Second Series, 1923); 1924. New York: Paul B. Hoeber, Incorporated; Demy 8vo., pp. 305, with 55 illustrations. Price: $5.00.

[2] "Aids to Practical Pathology," by F. W. W. Griffin, M.A., M.D., B.C. (Cantab.), M.R.C.S. (Eng.), L.R.C.P. (London), and W. F. M. Thompson; 1923. London: Baillière, Tindall and Cox; Foolscap 8vo., pp. 256, with three figures in the text. Price: 4s. net.

is well arranged and only those tests which have been in constant use by the authors are included. The satisfactory method of stating the interpretation of results as compared with the normal is followed. The increasing importance of the bio-chemistry of the blood and the urine is recognized in the comprehensive sections devoted to these subjects. The last of the ten sections into which the book is divided deals with special methods for the histological examination of material and the appendix contains such useful information as the preparation of standard solutions and the coefficients required for volumetric analyses. The book is to be recommended to the general practitioner who will find it most helpful in the carrying out of simple tests and in the interpretation of the results of those which he does not himself perform.

HYGIENE OF THE MOUTH.

ANYTHING from the pen of Dr. J. S. Wallace is always of interest and his little volume on oral hygiene, although provocative in tone, contains much material for reflection.[1]

The author has collected into one volume four of his papers delivered to meetings of medical associations or contributed to medical journals. Three of the four contributions have already been published.

In the first chapter the author deals with the physiology of oral hygiene. He regrets that physiologists continue their erroneous teachings in regard to oral hygiene and hopes that his efforts will stimulate research and induce them to give to the rank and file of the profession an authoritative lead.

He insists that oral hygiene is essentially a physiological process, that the function of the oral secretions is primarily the cleansing of the mouth and teeth and that saliva is not the first of the digestive juices as commonly taught. Mastication of fibrous food is a necessary part of the process, the fibres acting as a mop and cleansing the tooth surfaces. The mucus picks up food particles and is itself acted on by the alkaline saliva and is together with the adherent food removed by the detergent action of the fibres. The function of the saliva is *par excellence* oral hygiene. Ptyalin is not a digestive agent as any action on the starch is immediately arrested in the stomach, but its function is to dissolve and remove from the mouth lodging food particles.

One chapter is devoted to vitamins and dental hypoplasia and the author doubts that the lack of fat soluble vitamin A. is responsible for dental hypoplasia in children, as stated by some workers in this field.

Under the heading "Food and Teeth" the importance of correct diet and proper mastication is again emphasized. Much of the present day food cannot be masticated, nor does it stimulate a flow of saliva, under these conditions the physiological process breaks down and so we have unclean mouths.

The results are seen more particularly in children in whom lack of oral hygiene produces caries of the deciduous teeth. The loss of the deciduous teeth causes crowding of the permanent teeth and caries and more particularly pyorrhœa follows.

The progress of preventive dentistry is reviewed in the last chapter.

The book can be read with profit by both medical and dental practitioners.

INSANITY IN GENERAL PRACTICE.

IN an age when text-books on insanity are large and so full of detail and conflicting theories, that they are of use practically only to the alienist, Younger, in his "Insanity of Every Day Practice" is to be congratulated in presenting the salient essential facts of insanity within one hundred and thirty pages.[1]

Younger writes for the general practitioner who "with little or no knowledge of insanity has to deal with a case of mental aberration at a moment's notice." Whilst dealing for all practical purposes fully enough with the definition, causation, premonitory symptoms and the various mental disorders and their treatment, he lays stress on the futility of treating so many of the insane at home—a fact lost sight of by many practitioners.

The medico-legal difficulties and pitfalls of insanity are well dealt with and, although his remarks are based on English lunacy laws, they will be found very helpful to the Australian medical practitioner. At times the straining for conciseness defeats its own object. The chapter on hysteria and neurasthenia for example is so brief as to be well-nigh valueless. It is surely an oversight that the colloidal gold reaction—now universally used in the diagnosis of general paralysis of the insane—has not been mentioned.

Practitioners who wish to have the essential facts of insanity in small compass will not be without this book.

THE PARATHYREOID GLANDS.

A USEFUL addition and a much needed want has been supplied by Dr. H. W. C. Vines in his treatise on "The Parathyroids in Relation to Disease."[2] While most of the contents have already appeared in print in the various medical journals, the author has made a *résumé* in book form of convenient size of the position which the parathyreoids occupy in the treatment of disease. Yet the book does not lack the personal element; throughout every chapter the patient and earnest research of one who has applied himself to the difficult subject of organotherapy is manifest. The author purposely avoids any lengthy discussion of the condition of tetany owing to the vast amount of literature already published on that subject and refers to it mainly in conjunction with the other conditions with which he treats. But no book on parathyreoid junction would be complete without some reference to that condition which has stimulated research in connexion with these glands.

The orderly arrangement of the chapters and their sub-division into paragraphs which put forward clearly and concisely the main points with which each deals, render the book easily readable. After a short historical introduction, the anatomy, physiology and pathology of the glands are dealt with in a tentative manner, leaving to the remaining chapters the onus of proving, as far as possible, the temporary statements which are made. Recognizing that organo-therapy is but in its infancy and that much has yet to be done in the research laboratories, the author has carefully avoided the fault of dogmatizing where evidence is inconclusive; but the relation of the parathyreoids to calcium metabolism (to which he devotes a whole chapter) and their detoxicating power in the toxic states are well borne out in the pathological conditions (both convulsive and non-convulsive) with which the succeeding chapters deal.

The pharmacology of parathyreoid preparations and the inter-relation of the endocrine and the autonomic systems bring to a conclusion a book which is well worth perusal by every medical practitioner. While in no way minimizing the value of symptomatic treatment of disease, the author aims at something more radical by increasing the resisting power of the individual to the infective (acute and chronic) states. The research student will find much food for reflection and many indications of the direction in which valuable additions can be made to medical knowledge.

[1] "Oral Hygiene," by J. Sim Wallace, D.Sc., M.D., L.D.S.; 1923. London: Baillière, Tindall and Cox; Demy 8vo., pp. 83. Price: 5s. net.

[1] "Insanity in Everyday Practice," by E. G. Younger, M.D. (Brux.), M.R.C.P. (Lond.), D.P.H., Etc.; Fifth Edition, Revised and Edited by G. W. Smith O.B.E., M.B., Ch.B. (Edin.); 1924. London: Baillière, Tindall and Cox; Crown 8vo., pp. 144. Price: 5s. net.

[2] "The Parathyroid Glands in Relation to Disease." by H. W. C. Vines, M.A., M.D.; 1924. London: A. Edward Arnold and Company; Demy 8vo., pp. 135. Price: 10s. 6d. net.

The Medical Journal of Australia

SATURDAY, AUGUST 16, 1924.

Diseases and Death in Child-birth

A few weeks ago we called attention to the need for a complete remodelling of the medical curriculum in connexion with the teaching of obstetrics. The high maternal morbidity and mortality and the immense waste of infant life render this reform essential. In his address as President of the Section of Obstetrics and Gynæcology of the Australasian Medical Congress (British Medical Association), Melbourne, 1923, Dr. J. A. Cameron pointed out that during the past seventy years there had been no reduction in the maternal mortality; now as then one woman in every two hundred died in childbirth. This matter is at last recognized as one of the most urgent problems with which those responsible for the welfare of the Australian community are faced. The leaders of the medical profession have for many years indicated the seriousness of the situation and, even if the general development of what is termed preventive medicine has rendered this matter easier of attack during recent times, we must realize that it is an old problem that should have been solved years ago. The advocacy of making efforts to reduce this high morbidity and mortality by Dr. Fourness Barrington, by Dr. T. G. Wilson, by Dr. J. C. Windeyer and by a score of others, the demand of the Federal Committee for a better expenditure of the baby bonus so that there might be a sensible reduction in these illness and death figures and the efforts of practically every Branch of the British Medical Association in Australia to control the midwifery nurse and midwife and to improve the practice of midwifery are indications that the medical profession is alive to the necessity of a serious and radical reform. In this connexion it may be well to take note of a tendency to base reforms on hypotheses and doctrines evolved on insufficiently proven data. The fact is admitted that the maternal morbidity and mortality and the infantile mortality are much too high. The actual causes of these excessive rates, however, have not been analysed with completeness. Opinions are frequently expressed that the untrained midwife is the main factor in the occurrence of puerperal infection. Others blame the trained midwifery nurse who, armed with a certificate gained after a short period of training and after the passing of an easy examination, is said at times to be too prone to rush in where more experienced obstetricians fear to tread. Again others would trace the high infection rate to the busy doctor who confines his patients in their own homes under unfavourable circumstances. Hurry, unsuitable environment and want of proper precaution are supposed to contribute to the unfortunate results. It is possible that all three factors may be involved. But we have need for exact information. It would be of great importance if an analysis could be made of the circumstances under which a hundred consecutive disasters from puerperal infection have taken place in Australia. We are told that eclampsia and similar emergencies of obstetric practice can be prevented by adequate ante-natal supervision and anticipatory treatment. Dr. Windeyer has recorded some extraordinary facts which may be used to great advantage in building up a scheme of reform. Our knowledge, however, of the prophylaxis of these complications of labour is incomplete and more information should be collected without loss of time. We have yet to learn in the school of experience with hard facts—not impressions or recollections—before us, whether the maternal morbidity and mortality are lower in hospital or in private houses, what the fluctuations in these rates are due to and which forms of ante-natal care yield the best results. Dr. N. H. Fairley and Dr. R. Fowler have delivered an invaluable lesson in prophylaxis in connexion with syphilitic infections of the parturient woman. More information is needed to link up this work with the practice of obstetrics throughout the Commonwealth.

The splendid movement of the Melbourne Permanent Committee for Post-Graduate Work in instituting a prize in obstetrics rendered possible by the munificence of an anonymous patriot is likely to bring forth much of the needed information. The establishment of an obstetric department of the Alfred Hospital, Prahran, where all the machinery

attaching to a large teaching hospital may be utilized for the purpose of tracing the last cause of maternal morbidity and mortality, is another important step in the right direction. If it can be demonstrated—and it would seem as if proof will soon be forthcoming—that the woman in labour is safer when she has had the advantage of a well organized ante-natal clinic and when she is delivered in the wards of a properly equipped maternity ward or maternity hospital, the sooner the medical profession prepares itself to take charge of ante-natal clinics and maternity wards, the sooner shall we be justified in demanding the establishment of these admirable institutions in sufficient numbers to cover the needs of the whole population. At present there are but few clinics and the number of beds set aside for the lying-in woman is limited. Still more limited is the number of medical practicioners specially trained to do the work scientifically and effectively. While the facts are being sought, let us prepare ourselves so that as soon as the reform is initiated, the medical profession may be found competent to carry into effect the prophylactic measures for which it is clamouring.

Current Comment.

CARCINOMA AND SARCOMA.

IT is usually held that carcinoma and sarcoma are separate neoplastic diseases, possessing in all probability no common ætiological foundation. From a clinical aspect each has its distinct characteristics and peculiarities. The malignant quality of the growths is not essentially the same, although under certain conditions it may not be possible to define the difference. Histologically the neoplasms can be differentiated when typical, but some forms of sarcoma present curious divergences from the typical round-celled, spindle-celled or mixed varieties and may present varying degrees of similarity to epithelial growths. Atypical carcinomatous growths are seen at times in which cells indistinguishable from the typical round or spindle cells of sarcoma occur. In the course of the study of transplantable mouse cancers, Bashford, Woglom and Russell, Lewin and others reported the transition of mammary carcinoma to sarcoma. Apart from the question whether mammary carcinoma of mice is the same disease as adeno-carcinoma of human beings, there is considerable doubt whether the round and spindle cells which appeared in the successive generations of these mouse cancers, actually indicated a true sarcomatous change. This question and indeed all those bearing on this subject must remain undecided as long as the ætiology of the several forms of malignant diseases is unexplained. For the present there is apparently good ground for assuming that the carcinomata and the sarcomata represent a number of distinct pathological processes. If such a possibility be recognized, it must further be assumed that it may be unsafe to classify these diseases solely on histological characters. It is often hazardous to dogmatize on the origin of any given group of cells in a neoplasm. Exceptionally a section may be obtained of a very early hyperplasia of epithelial cells and when this is seen, there need be no hesitation in tracing the disorderly overgrowth of cells to their tissue of origin and in demonstrating the fact that these cells differ from their progenitors in that they no longer perform their physiological functions, but exist as parasites at the expense of their host. More often, however, the identification of the origin of the cells composing an epithelial neoplasm is a matter of indirect or inductive reasoning. In some cancerous tumours all attempts at identification of the components cells is pure speculation.

Dr. E. M. Hanrahan (junior) has recently described two tumours in which the significance of spindle cells has caused diagnostic doubts.[1] A woman had a trauma to the breast in 1904. In 1910 the breast was removed together with the pectoral muscles and the axillary lymphatic glands on account of a tumour recognized as Paget's disease of the breast. In 1921 a lump appeared close to the scar of the operation. The swelling was incised on the assumption that an abscess was present, but the tumour was not completely removed. Later an operation was carried out, but it was found that the tumour extended beneath the ribs and was connected with the pleura. Radium treatment was applied, as surgical measures were inapplicable. Although the growth at one time seemed to be regressing, the patient's condition gradually became worse and she died. A microscopical examination of the recurrent tumour removed in 1921 revealed that it was made up of large and small, irregularly-shaped spindle cells, lending to the specimen the appearance of a sarcoma. In addition, however, there were islands and areas of typical epithelioid cells, arranged in the sheet-like fashion of squamous-celled carcinoma. Mitoses in these cells were numerous. Three weeks later the tumour yielded specimens having an altered appearance. There were no longer any spindle cells; the greater number of the cellular elements were polymorphonuclear neutrophile cells and lymphocytes undergoing necrosis and scattered among these were large, swollen cells, resembling the epithelioid cells seen in the first section. These cells stained more intensely with hæmatoxlin and contained fewer mitotic figures.

The second patient to whom the author refers, had two tumours, one having the appearance of a mixed-celled sarcoma in the popliteal region and the other a purely round-celled sarcoma in the femoral region. He raises the question whether the femoral growth was a metastatic tumour of the former, made up only of the one element of the mixed cells, or whether

[1] *Bulletin of the Johns Hopkins Hospital*, February, 1924.

the popliteal tumour was made up of a single type of cell which was capable of occurring in two quite different forms. In regard to the first patient, he is inclined to the opinion that the spindle cells were in fact epithelioid cells undergoing a morphological change and that the capacity to undergo this change was lessened by the application of radium. He discusses other possible explanations of these two anomalies. It is important that observations of this kind should be placed on record, for it is only by the accumulation of irrefutable facts that the basis of a sound pathogenesis can be determined. We should prefer to leave the facts to speak for themselves at present. It is impossible to prove what was the origin of the spindle cells in the recurrent mammary tumour or why they but not the epithelioid cells disappeared after radium had been applied. It is also mere guess work to endeavour to reconcile the presence of round and spindle cells in the femoral tumour and of round cells only in the popliteal tumour in the second patient. Further study will no doubt reveal the significance of sarcoma-like cells in carcinoma and disclose the true pathology of the so-called carcino-sarcomata. Ingenious speculations concerning the inclusion of *Anlagen* held to lie dormant in some adeno-fibromata does not lead us very far.

MULTIPLE POLYPOSIS OF THE GASTRO-INTESTINAL TRACT

In our issue of December 30, 1922, reference was made to a communication from G. Percival Mills appearing in *The British Journal of Surgery* on the rare condition as *gastritis polyposa* or multiple polypi of the stomach. It was pointed out that Menetrier in 1888 gave the first complete description of the condition and that he described chronic inflammatory changes as occurring between the polypi. The findings of Mills differed from those of Menetrier. He observed no evidence of inflammatory change and took exception to the term *gastritic polyposa* on these grounds. Multiple polyposis occurs in other parts of the gastro-intestinal tract and it has been stated that it is not as uncommon as was formerly believed. Polypoid projections of the intestinal mucosa are seen fairly frequently at autopsies and the association of such excrescences with a clinical history of dysentery is relatively common. Among those who have described such polypoid formations are Wagner, Lebert, Luschka, Virchow, and Woodward. In 1920 J. E. Struthers published a comprehensive and interesting review of the subject and recorded seventy-one cases which he had collected from the literature. Dr. Struthers has made a further communication and has added thirteen cases to his earlier list. In addition he has given an account of twenty cases of polyposis occurring in patients admitted to the Mayo Clinic between February 1, 1920 and January 1, 1923.[1]

The clinical history and findings in one patient are of interest when considered in the light of Mills's work. The patient was a man, forty-eight years of age, who was seen in May, 1919 on account of "epigastric pressure and a lump in the abdomen." There was a family history of carcinoma and the clinical signs were such that it was thought advisable to perform laparotomy. This was done and thickening of the pyloric half of the wall of the stomach was found. The stomach was examined from within. Definite thickening of the muscular wall and hypertrophy of the mucous membrane with puckering round the pylorus were found. No evidence of malignant disease or of ulceration was found though these were carefully sought. Gastro-enterostomy was performed. A piece of the puckered mucous membrane was removed for microscopical examination. It was found to be the seat of inflammatory reaction. In 1920 the patient returned to the clinic with acute gastric symptoms of one month's duration. Operation was again performed and the gastro-enterostomy was separated. A gastro-jejunal ulcer was found together with definite polyposis which had undergone malignant change. In his discussion of this case Dr. Struthers points out that there was tictile, visual and biopsy proof of chronic gastritis with hypertrophy of the muscular wall and mucous membrane of the stomach followed by polypoid growths and finally by carcinomatous change in these growths. There was no ulceration in this part of the mucosa. He thinks that this case belongs to the group described by Menetrier as *polyadénomes polypeux* and regards it as tending to confirm Menetrier's opinion of their inflammatory origin. He states that there is no case in the literature which so confirms the correctness of the term *gastritis polyposa*.

[1] *Surgery, Gynecology and Obstetrics*, May, 1924.

LONG DISTANCE RUNNING.

In recent years various attempts have been made to ascertain whether the sustained effort of a Marathon race produces a measurable effect on the size of the heart, on the vital capacity and on the blood pressure of normal individuals. The competitors in these races usually have undergone training extending over several months or years, involving repeated and sustained muscular strain. Dr. Burgess Gordon, Dr. S. A. Levine and Dr. A. Wilmaers have added to the literature of this subject.[1] Their findings that the vital capacity of men after a race of twenty-five miles usually falls about 15%, but returns to normal within twenty-four hours is unfortunately of small importance, in view of the results of careful investigations by Lucy D. Cripps and others. This matter will be discussed at length in a subsequent issue. It appears that all attempts to set up a normal standard of vital capacity for healthy individuals have failed. The authors found that the hearts of the runners diminished rather than increased in size after the race. This would indicate that years of physical effort do not produce cardiac hypertrophy. They noted a slight fall in the blood pressure immediately after the race, with a rapid return to the previous level. They regard this, too, as of no moment.

[1] *Archives of Internal Medicine*, April 15, 1924.

Abstracts from Current Medical Literature.

LARYNGOLOGY AND OTOLOGY.

Maxillary Hyperplasia.

DOUGLAS GUTHRIE (*The Journal of Laryngology and Otology*, November, 1923) records the cases of two patients suffering from the somewhat rare disease of chronic hyperplasia of the upper jaw. One patient, a girl, aged sixteen years, presented a smooth painless swelling of the left upper jaw which had been present a year and chiefly affected the lower part of the canine fossa. The other patient, a boy, aged four years, had had a similar unilateral condition from birth. In both there was a greatly thickened alveolar margin. Guthrie quotes other cases recorded and concludes that the condition is a definite pathological entity having no connexion with syphilis, with tuberculosis or with malignant disease. It has no connexion with acromegaly or *osteitis deformans*. *Leontiasis ossea* has been regarded, the author thinks without definite proof, as an advanced stage of chronic hyperplasia of the upper jaw. Retrogression has not been observed and there is no record of the disease becoming malignant. Histologically the appearance of the bone resembles that found in oto-sclerosis, though deafness has not been noted in any of the recorded cases.

Conservatism in Ethmoid Surgery.

EDWIN MCGINNIS (*Journal of the Indiana State Medical Association*, November 15, 1923) outlines his method of dealing with ethmoid suppuration. He says that in most instances a preliminary high nasal septum operation is required. With the patient sitting upright the anterior end of the middle concha and the area above it as far up as possible together with the septal area opposite are swabbed with one in one thousand adrenalin. After shrinkage another application of adrenalin is made on both sides of the concha and the ethmoid bulla. Then two applications of a 20% solution of cocaine are made to these surfaces. After a few minutes with the patient's hed in extreme extension open Grünwald's forceps are inserted into the anterior ethmoid above the attachment of the middle concha and the latter is left intact. The inferior, superior and posterior walls of any agger cells and above these part of the front wall of the naso-frontal duct are cut away. The free border of the concha is pushed with the forceps towards the septum and the front of the lower cell of the bulla is bitten away. A channel is then cut through the front wall of the bulla to the frontal ostium. A channel may then be made through the posterior and upper wall of the bulla into the posterior ethmoid labyrinth. All the cutting is done under direct vision in an up and down direction parallel with the orbital and turbinal plates. The normal cell ostia are not disturbed, no after treatment is necessary.

Unsuspected Nasal Sinus Disease.

T. B. JOBSON (*The Lancet*, November 10, 1923) states that nasal sinus disease is much commoner than is generally supposed. When infected these are constantly secreting pus, a good deal of which is swallowed. Toxins are absorbed both by the mucosa of the sinus and of the intestinal tract. A chronic toxæmia is produced which may show itself in many ways *exempli gratia*, headaches, arthritis or nephritis. The pus swallowed may set up infection in any part of the intestinal canal. Treatment of the secondary conditions will produce little benefit while the toxic source is still present. Surgical treatment of the sinuses gives excellent results. Early diagnosis is of great importance. Vaccines are useless in chronic forms, but in the acute and sub-acute varieties they are no doubt of help in treatment. Headache, commonly frontal, is a usual symptom of sinusitis. In acute maxillary, ethmoidal and frontal conditions it is a brow-ache. In chronic conditions the pain is higher. Occipital headache points more to an involvement of a sphenoidal sinus. The headache is usually matutinal, the patient wakes with a dull pain which lasts for hours until the pent-up secretions are more or less evacuated. Headache may be the only symptom of chronic sinusitis. The similarity between the symptoms of sinusitis in children and those of adenoid hypertrophy should be kept in mind.

The Nasal Cavities and Sinuses.

J. F. O'MALLEY (*Journal of Laryngology and Otology*, February, 1924) says that the organ of smell apparently at first was concerned only with olfaction, later it was related to taste and assimilation and still later to respiration. As respiration began to predominate the more primitive function of olfaction receded. The specialized structure of the adult of a lower class becomes vestigial in the adult of a higher class, but in the developing embryo of the latter it is always reproduced to be repressed later. There are three stages reproduced in the development of the human embryo: (i.) A jiscine in which nose and mouth are formed independently; (ii.) an amphibian stage in which the nasal respiratory passage opens on the roof of the mouth and (iii.) a mammalian stage in which it opens into the naso-pharynx. The human fœtus at the fourth month has six turbinates. In the adult the first persists as the inferior, the second as the middle, the third and fourth unite to form the superior, the fifth disappears, and the sixth forms the sphenoidal turbinate. The *agger nasi* corresponds to the naso-turbinates of carnivora and keen-scented animals. With the limitation of the turbinates is a corresponding reduction in the area of sensory epithelium. The nasal accessory sinuses have no representation in the animal kingdom below reptiles. The face is developed from the basal portion of the skull the real core of which is the olfactory cartilaginous capsule. Bones pre-formed in cartilage have the peculiarity of forming large air spaces, which give the necessary bulk and strength to the framework of the face without adding to its weight. In embryonic life the formation of these sinuses seems to be preceded by or associated with a budding out of the mucous membrane lining the lateral walls of the nose which keeps pace with the cavitation yet retains continuity with the nasal cavities, and possesses the same type of respiratory epithelium. The size and development of the maxillary sinuses are concerned with the growth of the teeth. The frontal sinus bud is present in birth in the ethmoid region and lies undeveloped until the fifth year. Perhaps the most important function which the air sinuses have in man, is that of resonating chambers in relation to speech.

Intrinsic Cancer of the Larynx.

J. S. FRASER AND DONALD WATSON (*Journal of Laryngology and Otology*, February, 1924) report the findings in fourteen cases of intrinsic cancer of the larynx. Twelve patients were men. The ages of the patients varied from thirty-six to seventy-six years. There seemed reason for supposing that cancer appearing in a comparatively young person is likely to be of a rapid and malignant type. In all the cases a piece was removed by the direct method by Pfau's double cutting forceps after permission for operation had been obtained. In all but one the report was "squamous epithelioma," in the other patient who appeared to be suffering from hyperkeratosis, subsequent microscopic examination revealed invasion of the deeper tissue. Thyrotomy was employed in all instances. Seven patients recovered, seven died. There was no recurrence after seven, six, four (twice), two (twice) and one year after operation. Of the seven patients who died, one died of apoplexy, three of pulmonary complication following operation and three of recurrence of local disease. Excision of the larynx, the authors state, should have been carried out in several of those treated by thyreotomy. They conclude that thyreotomy is a suitable operation for the cure of cancer of the larynx in a comparatively small group of patients. Patients suffering from definite arterio-sclerosis, from chronic pulmonary affections or from syphilis should not be operated upon. Thyreotomy is only indicated if the growth on the vocal cord is a limited one, *id est*, if it does not transgress the anterior commissure or reach the vocal process and if the cord itself is fairly movable. In cases where the growth has extended deeply and the cord moves very little or not at all, the proper procedure is laryngectomy. Cancer tends to infiltrate between the thyreoid and cricoid cartilages, so that the removal even of a large piece of the thyreoid cartilage may not be sufficient to prevent recurrence.

OPHTHALMOLOGY.

Chorio-Retinal Atrophy with Scleritis.

B. W. KEY (*American Journal of Ophthalmology*, November, 1923) reports the case of a man of thirty years who complained of repeated attacks of inflammation of the right eye for a period of eleven years. At the time of examination the right eye was quiet and looked normal externally, but the fundus showed extensive chorio-retinal changes and vision was reduced to perception of light. The left eye was normal. Two years later he returned with an acute attack of scleritis, two well-defined violaceous and vascular tumefactions of the deep sclera in the upper and lower temporal portions of the globe, slight exophthalmos, sluggish pupil and the vitreous filled with floating particles obscuring the fundus. The serum did not react to the Wassermann test. He was given mercury and potassium iodide for a month and the eye became quiet again as at the time of the first examination. The author has not found recorded any similar case, though the association of uveitis with scleritis is not at all uncommon.

Impacted and Unerupted Teeth in Ocular Disorders.

E. STIEREN (*The Atlantic Medical Journal*, February, 1924) draws attention to the rôle of impacted teeth in certain cases of asthenopia which are not relieved by any optical correction. Reflex irritation from the teeth may result in trophic disturbances in the eye and interference with the function of the ocular muscles. A woman, thirty years of age, with moderate hypermetropia and astigmatism could get no relief from the use of glasses. An X-ray examination revealed an unerupted and impacted left lower third molar tooth. Its removal effected a cure. Another woman of thirty-one with even less error found no relief until an unerupted right upper third molar tooth and an unerupted left upper third molar tooth were discovered and extracted. In a third patient the upper right second bicuspid tooth was unerupted, its crown was impinging on its fellow bicuspid and first molar. The relief following its extraction was "miraculous." Two cases of punctate keratitis were cured in like fashion. In one instance the onset of glaucoma was attributed to a horizontally lying impacted molar, the removal of which relieved the condition.

Traversing Wounds of the Orbit.

D. M. GREIG (*Edinburgh Medical Journal*, April, 1924) publishes a long account of traversing wounds of the orbit as opposed to penetrating wounds. As a text for his remarks he relates the case of a boy whose left orbit was struck by an umbrella rib. He at once became unconscious and suffered from intense shock. There was a small punctured wound below the mesial canthus of the left ear. On the fourteenth day his left hand was shaky and he dragged his left foot; there was paralysis of the left external rectus, but no diplopia. A year later he still had a shambling gait and some blurring of the edges of both optic discs. He ultimately recovered. The umbrella rib entered the superior orbital fissure wounding the abducent nerve; it then passed through the left cerebral peduncle in the region of the red nucleus and the *substantia nigra*. Perforation of the orbital plate seems to occur in the majority of traversing wounds of the orbit. The absence of initial symptoms gives the impression that the injury is trifling, but these generally end fatally. A man was prodded in the left ear by the ferrule end of an umbrella. Two days later he became drowsy and died. *Post mortem* examination revealed perforation of the orbital plate into the anterior lobe of the brain and left nentucle. A woman was struck by her husband with a tobacco pipe. She had no discomfort for several days; she then became delirious and died. On *post mortem* examination it was found that twelve millimetres of the end of the pipe had gone through the sphenoid bone by the side of the *sella turcica* and lodged in the brain where it lay embedded in pus.

Phaco-Anaphylactic Endophthalmitis.

A. N. LEMOINE AND A. E. MACDONALD (*Archives of Ophthalmology*, March, 1924) publish the results of their investigation on lens protein hypersensitiveness in one hundred and sixty-eight persons. Pig's eyes are obtained a few hours after death and the lenses extracted and allowed to dry. This takes from twenty-four to seventy-two hours. They are then pulverized and for injections are dissolved or suspended in normal saline solution in a known percentage. Of the one hundred and sixty-eight persons fourteen yielded reactions. In seven whose cataracts had been removed and cortical matter had been behind, intra-ocular inflammation developed. Those who did not react, were not attacked by inflammation. Two hypersensitive patients were successfully desensitized and were successfully operated upon for immature cataract. Therefore patients with immature cataract, if hypersensitive to lens protein, should be desensitized before operation.

Mathematical Values of the Snellen Notations.

A. C. SNELL (*American Journal of Ophthalmology*, April, 1924) states that the fractions employed to denote visual aciuty by the Snellen's types must not be taken as true fractions indicating what proportion of total sight the individual in question possesses. At the same time in view of workmen's compensation, it is important to be able to deduce from the fraction employed to express visual acuity the percentage of vision present. The standard is a letter subtending an angle of five minutes, say at six metres (twenty feet), above. This one letter which should be seen at twelve, eighteen, twenty-four, thirty up to sixty-six metres (220 feet) ascending in arithmetical progression. The visual acuity fraction compares only one fraction of vision with another fraction; it does not compare it with the whole vision. A standard full vision must be assumed and a standard zero vision. Assuming the six metre letter as full vision and the sixty-six metre as industrial blindness the percentage of vision is obtained from the formula $\frac{220 - D.}{200} \times 100$ in which D. = Snellen denomination. Thus $^{20}/_{20}$ works out as 100% and $^{20}/_{40}$ as 90% and so on. This ascension in arithmetical progression is not so accurate as an ascending geometrical progression with a convenient common ratio of 1.26. So the distances with corresponding letters are taken as 20, 25, 32, 40, 50, 64, 80, 100, 126, 160, 200, 250, and 320. For industrial purposes $^{20}/_{20}$ and $^{20}/_{320}$ may be regarded as full and zero vision. There are ten gradations between them. The percentage of vision is therefore $\frac{R.-P.}{R.} \times 100$, R. being number of ratios employed (here 10) and P. the number of the gradations which measures any partial degree of visual acuity. Thus in $^{20}/_{40}$ P. = 1 (the first gradation from $^{20}/_{32}$) vision = 90%; $^{20}/_{50}$ works out as 80%. A table and a graph set out the percentages.

Operation for Ptosis.

GEORGE YOUNG (*British Journal of Ophthalmology*, June, 1924) describes a successful operation for ptosis on a girl of seventeen years. The superior rectus was exposed for about one centimetre. This was freshened with a sharp scalpel where the upper edge of the tarsus crossed it. The upper end of the tarsus was exposed to the extent of the width of the muscle and by means of three silk sutures, one taking in the central fibres of the muscle and the other two the two edges, the whole width of the superior rectus was firmly sutured to the tarsus. Among other benefits she was relieved of a troublesome tic of the frontalis muscle.

A New Operation for Glaucoma.

W. H. LUEDDE (*American Journal of Ophthalmology*, May, 1924) has suggested a new procedure for glaucoma or rather a modified technique for an iridectomy. After reflecting a conjunctional flap and splitting the cornea for a millimetre or two the anterior chamber is opened with a keratome by an incision not more than two millimetres wide. The wound is enlarged on each side for two millimetres by scissors; the wound thus made being bruised so that it does not heal too firmly. The iridectomy is then performed.

British Medical Association News.

ANNUAL MEETING.

THE ANNUAL MEETING OF THE SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held in the Lister Hall, Hindmarsh Square, Adelaide, on June 27, 1924, DR. JAMES RIDDELL, the President, in the chair.

Annual Report of Council.

The President presented the Annual Report of the Council as printed below. A copy of the report had been sent to every member of the Branch.

REPORT OF THE COUNCIL FOR THE YEAR ENDED JUNE 30, 1924.

Membership.

The membership of the Branch now stands at 323, showing a net increase of sixteen for the past twelve months. It is with regret that the deaths of Drs. T. Borthwick, F. W. Noble and E. M. Steven are recorded.

Meetings.

Eight ordinary and five special general meetings were held during the year and the Council met for business on thirteen occasions. The Lodge and Ethical Committee met five times. The meetings have been well attended, and at the July general meeting, when the subject of "Insulin" was dealt with, over eighty members were present. The attendance at Council Meetings were as follow: Dr. Riddell, 13 meetings; Dr. Scott, 12 meetings; Dr. Wilson, 9 meetings; Dr. Newland, 10 meetings; Dr. Swift, 13 meetings; Dr. McEwin, 5 meetings; Dr. Verco, 10 meetings; Dr. de Crespigny, 11 meetings; Dr. Pitcher, 12 meetings; Dr. Cherry, 12 meetings; Dr. Ray, 10 meetings; Dr. Hone, 5 meetings (resigned, February, 1924); Dr. Smeaton, 4 meetings (from February, 1924).

Annual Dinner.

The Annual Dinner was revived again last year and was a great success. It will be held this year on Friday, June 27, at 7.30 p.m. and already a large number of members have signified their intention of attending. Will those who wish to be present please let the Secretary have the butt of the ticket back as soon as possible, so that the catering arrangements can be finalized? Tattersalls Club has kindly offered to grant complimentary tickets for the race meeting on Saturday, June 28 to country members and their wives.

Representation on Boards.

Dr. W. A. Verco has been nominated to represent the Branch on the Medical Board for a further term of two years from June 15, 1924, and Dr. F. Steele Scott has been nominated to represent the Branch on the Nurses' Registration Board for a further term of two years from June 10, 1924.

Federal Committee.

The Federal Committee met for business twice during the year. In February last Dr. F. S. Hone found it necessary to resign his post as one of the two representatives and Dr. Bronte Smeaton was elected in his stead. Dr. H. S. Newland and Dr. Hone attended the first meeting and Dr. Newland and Dr. Smeaton the second meeting.

National Insurance.

As members know the commission which visited Adelaide recently took evidence from various sources on the subject of national insurance, Drs. F. Steele Scott and

THE SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

Income and Expenditure Account for the Year Ended December 31, 1924.

EXPENDITURE.

	£	s.	d.
To British Medical Association, London,—Subscription Account	377	4	3
THE MEDICAL JOURNAL OF AUSTRALIA—Journal Account	298	10	0
„ Federal Committee—Capitation Grant	28	12	0
„ Delegates' (Federal Committee) Expenses	19	0	3
„ General and Entertainment Expenses	17	13	6
„ Stationery, Printing and Advertising	29	11	6
„ Postages and Telegrams	27	4	11
„ Salary Account	125	0	0
„ Hire of Lister Hall	26	5	0
„ Telephone and Duty Stamps	9	19	9
„ Audit fees (two years)	8	8	0
„ Exchange Account	0	14	8
„ Legal Expenses	2	15	0
„ Depreciation of Plant written off	13	2	10
„ Balance, being excess of income over expenditure transferred to General Fund Account	300	10	4
	£1,284	12	0

INCOME.

	£	s.	d.
By Subscriptions Received	1,201	12	0
„ Subscriptions due and unpaid	22	10	0
„ Interest	56	0	0
„ Dividend	4	10	0
	£1,284	12	0

General Fund Account.

	£	s.	d.
To Transfer to Library Fund Account	90	0	0
„ Balance Carried down	1,038	0	7
	£1,128	0	7

	£	s.	d.
By Balance at December 12, 1922	827	10	3
„ Income and Expenditure Account Transfer of Surplus for year	300	10	4
	£1,128	0	7
„ Balance brought down	1,038	0	7

Library Fund Account.

	£	s.	d.		£	s.	d.
To Purchase of Delineascope	55	2	10	By Balance at December 12, 1922	129	18	6
„ University Library Grant Account paid	50	0	0	„ Interest—Savings Bank	2	0	0
„ Balance carried down	171	18	6	„ Transfer from General Fund Account, being 180 City Members' Subscriptions at 10s.	90	0	0
				„ Delineascope Account (Library Fund)	55	2	10
	£277	1	4		£277	1	4
				„ Balance brought down	171	18	6

Balance Sheet as at December 31, 1923.

LIABILITIES.	£	s.	d.	ASSETS.	£	s.	d.	£	s.	d.
British Medical Association, London	26	15	6	Plant Account	131	8	8			
THE MEDICAL JOURNAL OF AUSTRALIA	91	10	0	Less written off	13	2	10			
Sundry Creditors	69	6	4					118	5	10
Medical Benevolent Fund	2	0	6	Delineascope Account (Library Fund)				55	2	10
Medical Defence Association	1	17	6	Commonwealth Loan, 6%, 1930 (Face Value £700)				691	3	6
Library Fund Account	171	18	6	Commonwealth Loan, 5%, 1948 (Face Value £400)				403	12	0
Subscriptions paid in advance	7	8	0	Savings Bank of S.A. (Library Fund Account)				32	5	8
General Fund Account	1,038	0	7	Subscriptions Due				22	10	0
				National Bank of Australasia, Ltd., Amount at Credit				69	10	8
				Cash in Hand				16	6	5
	£1,408	16	11					£1,408	16	11

Audited and found correct as per Books and Vouchers produced.
C. W. L. MUECKE, F.I.C.A.,
Auditor.

(Signed) W. A. VERCO, Honorary Treasurer,
R. G. C. HODGE, Secretary.

Adelaide,
February 26, 1924.

H. S. Newland having represented the Branch. A form of questionnaire was circulated to members and the replies which were received were sent on to the Federal Committee for analysis and tabulation. The same was done by the other Branches and the Federal Committee will deal with the replies at its forthcoming meeting next month. The following resolution was passed at the Special General Meeting of the Branch, held on May 1, 1924:

> That this meeting of medical practitioners, while disagreeing with the necessity of any scheme of national contract practice under present Australian conditions, urges upon the Government the pressing necessity of a national scheme of research in the cause of disease, for the prevention of disease and for the establishment of sanatoria and ante-natal clinics and similar measures.

Listerian Oration.

The Council invited Dr. Fred. A. Hadley, of Perth, to deliver the Listerian Oration last month. There was a good attendance of members present. Dr. Hadley took his subject "Congenital Abnormalities of the Intestinal Tract" and the Council wishes to thank him officially for his interesting address.

Medical Treatment of Certain War Pensioners as Lodge Members.

The Repatriation Commission recently propounded a scheme (and submitted it to the Federal Committee) by which widows and orphans of deceased soldiers and widowed mothers of deceased unmarried soldiers would be able to obtain medical benefits as ordinary lodge members, without medical examination and without the income limit applying to them. The Federal Committee recommended to the Branches the acceptance of the scheme and this Branch agreed, on the understanding that the full number of eligible persons who elect to participate and who are approved by the Commission, shall be paid for irrespective of whether they are already lodge members or not.

JAMES RIDDELL,
President.

The report was adopted.

Financial Statements.

DR. W. A. VERCO, the Honorary Treasurer, presented the various financial statements (see pages 178-179). He commented upon the very satisfactory financial result for the year and pointed out that the sum of £300 10s. 4d., the surplus of income over expenditure, had been added to the general fund. He thought that perhaps the time had come when the subscription rate might be reduced and he gave notice that he would move in that direction at a later date.

The financial statements as printed were adopted.

Election of Office-Bearers.

The following were elected office-bearers and members of the Council for the ensuing year:

President: DR. F. STEELE SCOTT.

Vice-President: DR. C. T. C. DE CRESPIGNY, D.S.O.

Honorary Treasurer: DR. W. A. VERCO.

Honorary Secretary: DR. BRIAN H. SWIFT, M.C.

Members of Council: DR. M. ERICHSON, DR. F. H. BEARE, DR. H. P. BROWNELL.

Library Committee: DR. H. SWIFT, DR. A. A. LENDON, DR. H. S. NEWLAND, C.B.E., D.S.O., DR. W. RAY, DR. BRIAN SWIFT, M.C.

Representatives to the Federal Committee: DR. H. S. NEWLAND, C.B.E., D.S.O. and DR. BRONTE SMEATON.

President's Address.

DR. JAMES RIDDELL delivered his address (see page 159).

Induction of President.

DR. STEELE SCOTT, the incoming President, then occupied the chair. He thanked the members for his election and hoped that he would continue to uphold the position with dignity as his predecessors had done.

Vote of Thanks.

DR. F. S. HONE proposed a vote of thanks to the retiring President. He had worked hard in his office and had always had to travel a long way to the City to attend the meetings. DR. VERCO seconded the motion which was carried with acclamation.

DR. RIDDELL replied and thanked the members.

Sub-Committees for the Year 1924-1925.

At a meeting of the Council of the South Australian Branch held on July 10, 1924 the following sub-committees were appointed for the year ending June 30, 1925:

Scientific Meetings: DR. STEELE SCOTT (the President), DR. C. T. C. DE CRESPIGNY, D.S.O., DR. H. S. NEWLAND, C.B.E., D.S.O., DR. H. P. BROWNELL, DR. BRIAN SWIFT, M.C. (convener).

Lodge and Ethical: DR. STEELE SCOTT, DR. JAMES RIDDELL, DR. P. T. S. CHERRY, DR. F. H. BEARE, DR. M. ERICHSON, and the Lay Secretary (convener).

Parliamentary Bills, Medico-Political and Public Health: DR. H. S. NEWLAND, C.B.E., D.S.O., DR. BRONTE SMEATON, DR. W. RAY.

Revision of Rules: DR. H. S. NEWLAND, C.B.E., D.S.O., DR. C. T. C. DE CRESPIGNY, D.S.O., DR. W. RAY and the Lay Secretary (convener) with power to co-opt.

Post-Graduate Course: DR. STEELE SCOTT, DR. BRIAN SWIFT, M.C. and DR. W. RAY.

SCIENTIFIC.

A MEETING of members of the New South Wales Branch of the British Medical Association was held at the British Medical Building, 30 to 34, Elizabeth Street, Sydney, on June 18, 1924, for the purpose of inaugurating a special section of oto-rhino-laryngology.

It was resolved that a section be formed. The recognition of the Council of the New South Wales Branch has since been given.

The following were elected the office bearers for the ensuing year:

Chairman: DR. A. J. BRADY.

Vice-Chairman: DR. HERBERT MARKS.

Honorary Secretary: DR. GARNET HALLORAN.

Honorary Treasurer: DR. SEAWARD MARSH.

Members of Committee: DR. W. CHARLES MANSFIELD, DR. CHARLES WARREN, DR. R. S. GODSALL.

It was announced that membership was open to any member of the New South Wales Branch and that nominations should be forwarded to the Honorary Secretary.

A meeting of the Section will take place in the first week in October, 1924.

MEDICO-POLITICAL.

A MEETING OF THE VICTORIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held in the lecture room of the Walter and Eliza Hall Institute on July 2, 1924, Dr. J. W. Dunbar Hooper, the President, in the chair.

New Building.

The President said that the question of a new building for the Branch had been very earnestly considered by the Council and by the Building Sub-Committee of the Council.

By a resolution of July 4, 1923, the Branch approved a scheme involving the formation of a company for acquiring a building site for British Medical Association buildings; the company should bind itself to sell the property to the Branch at cost price.

After prolonged deliberations and careful inquiries the Council was of opinion that the alternative plan for building on the site of the present Medical Society Hall was more within the financial capacity of the Branch. They therefore asked for the recision of the resolution of July 4, 1923, in order that steps might be taken to erect a new building on the site of the present hall.

That the resolution in question be rescinded was moved by Dr. R. H. Ftherston, seconded by Dr. R. R. Stawell and carried unanimously.

Scale of Fees.

Copies of the standard scale of fees as recently revised by the Council were circulated. After some discussion in which suggestions for the adjustment of certain discrepancies were made, it was moved by Dr. J. F. Wilkinson:

> That this meeting gives the Council power to revise finally and ratify the scale of fees as circulated.

DR. L. DOYLE seconded the motion, which was carried unanimously.

Medical Clinics.

Papers based on their experiences and observations in medical clinics abroad were read by Drs. J. R. Bell, W. Cuscaden, L. Doyle, H. Jacobs and D. Rosenberg. These articles will be published in a subsequent issue.

DR. B. T. ZWAR expressed his appreciation of the several papers and said that he had been particularly interested in the remarks of Dr. Doyle concerning spinal anæsthesia. He felt impelled to sound a note of warning regarding the risks of spinal anæsthesia.

It was now nineteen years ago since he first saw this method used in Victoria and he was then very much impressed with its advantages, particularly for operations upon the bladder and pelvic organs. He subsequently had opportunities for extended observations on spinal anæsthesia and his experience embraced some five hundred instances of its use. He had employed "Stovaine," "Novocain," and "Tropococaine" for the production of anæsthesia by intra-thecal injection.

Although in a large proportion of cases the procedure was successful and unattended by any bad effects, there was a certain percentage of patients in whom undesirable symptoms were manifested. In a very few instances the outcome could not be described as otherwise than tragic. Transient and permanent nerve pareses were occasional sources of anxiety; the onset of paraplegia in one patient some time after the operation was particularly distressing and determined him in abandoning spinal anæsthesia.

Immediate untoward effects were induced in some patients. He well remembered a patient about to be operated upon for hæmorrhoids, who exhibited alarming collapse and fall of blood pressure immediately after receiving the intra-thecal injection.

He recognized that present-day technique may have eliminated the possibility of bad effects associated with spinal anæsthesia; when he had employed it he had been fully alive to the necessity of using pure drugs and avoidance of alkali contamination.

Dr. K. Stuart Cross inquired of Dr. Jacobs whether he had gathered any information relating to radiological pelvimetry. From recent experience in this work he had been much impressed with its possibilities in the direction of obtaining accurate measurements of the pelvis diameters.

Dr. Jacobs said that he had not actually seen radiological pelvimetry in practice, but he had had the privilege of hearing a paper and discussion on the subject in the obstetric section of the Royal Society of Medicine. It had there been allowed that remarkably accurate measurements could be made, but the question had been raised of the possible effects of the rays upon the fœtus.

NOMINATIONS AND ELECTIONS.

The undermentioned have been nominated for election as members of the New South Wales Branch of the British Medical Association:

DAWES, SYDNEY ROBINSON, M.B., Ch.M., 1923 (Univ. Sydney), Sydney Hospital.

HEWITT, GEORGE HENRY, M.B., 1923 (Univ. Sydney), Park Avenue, Burwood.

MATHESON, WILLIAM HARLOW, M.B., Ch.M., 1923 (Univ. Sydney), Mudgee.

MUNRO, FRANK VIVIAN, M.B. Ch.M., 1924 (Univ. Sydney), Nelson Bay Road, Waverley.

The undermentioned have been elected members of the Queensland Branch of the British Medical Association:

HALL, THOMAS MERVYN SEYDE, M.B., 1924 (Univ. Sydney), Mt. Mulligan.

MCLEAN, GORDON ALEXANDER, M.B., Ch.M., 1924 (Univ. Sydney), Toowoomba.

Medical Societies.

THE OPHTHALMOLOGICAL SOCIETY OF NEW SOUTH WALES.

Foreign Bodies in the Eye.

A MEETING OF THE OPHTHALMOLOGICAL SOCIETY OF NEW SOUTH WALES was held at the Eye Department, Sydney Hospital, on April 2, 1924, DR. R. H. JONES, the President, in the chair.

DR. R. B. NORTH read a paper entitled "Extraction of Foreign Bodies from the Eye" (see THE MEDICAL JOURNAL OF AUSTRALIA, August 2, 1924, page 108).

DR. H. G. ALLEN read a paper entitled "Foreign Bodies in the Eye and their Removal" (see THE MEDICAL JOURNAL OF AUSTRALIA, August 2, 1924, page 110).

In the course of his remarks Dr. Allen also referred to the case of a boy who had been sent to him with the history that while hitting a plough with a hammer something had struck his right eye. The vision in the right eye had almost immediately been affected to a considerable extent, so that the eye had become inflamed and painful. He had been seen by his usual medical attendant, but no suspicion of the presence of a penetrating wound had been entertained. Dr. Allen had seen the boy five days after the accident. The right eye had then been acutely inflamed and a perforating wound of the cornea in about the "three o'clock" position had been noted. There had also been a tear in the iris at the ciliary margin behind the corneal wound. Much iritis had been present and the pupil had been occluded by fibrinous exudate. Vision in the right eye had been reduced to perception of light. X-ray examination had revealed the presence of a foreign body in the posterior portion of the globe, in the retina and on the temporal side of the disc. Injury to the lens had been doubtful at the time of operation owing to the occlusion of the pupil. Under general anæsthesia the right globe had been opened above and as far back as possible by the posterior method. A small piece of steel had been removed by the hand magnet introduced into the lips of the scleral wound. Dr. Allen said that he felt convinced that if any attempt had been made to bring it forward into the anterior chamber by the large Haab's magnet, the result would have been hopeless. Milk injections had been given for four days and the eye had settled down wonderfully well. A lot of damage had been done to the fundus by the entrance of the foreign body. All inflammation had subsided in about three weeks and the vision had improved so that the patient was able to count fingers at two metres. The cosmetic result was very good. Dr. Allen said that those who advocated the adoption of the anterior route, would probably say that the fundus had been damaged by opening the sclera and introducing a magnet. The vision prior to operation, however, showed that the fundus had been damaged. Ophthalmoscopic examination showed a lot of vitreous disturbance in the track of the foreign body and considerable hæmorrhage in the fundus. There was a somewhat glistening spot near the macula, the site of the former foreign body. This was probably a tear in the retina and the chief cause for the defective vision.

Dr. Allen read further notes of patients who had been in the Newcastle Hospital with foreign bodies in the globe. Two patients were under treatment at the time of the meeting. Both had perforating wounds of the corona with injury to the lens and pieces of steel in the vitreous. Both patients had been placed before the large electro-magnet and under local anæsthesia the foreign bodies had been successfully removed through the original wound of entrance. The visual acuity was $^{6}/_{18}$ in one patient and "$^{6}/_{9}$ letters" in the other. Protein therapy had been used in both instances. It had been stated that foreign bodies should not be removed through the original wound of entrance. Dr. Allen had referred to these two cases to show that no definite rule should be followed in treating penetrating wounds of the globe with magnetizable foreign bodies in the interior. Each case had to be decided on its own merits.

DR. J. C. HALLIDAY said that he had used the Mellinger magnet and thought that it was the more modern way. He agreed with Dr. North in regard to the delay of a few hours to effect dilatation of the pupil. He had extracted a certain number of foreign bodies by the posterior route with satisfactory results.

DR. GUY ANTIL POCKLEY stated that his personal experience had in some respects been similar to those of Dr. Allen. He had had experience of all three methods, but on the whole was in favour of the Snell method with a posterior incision. He was very disappointed with the Mellinger magnet and had had greater success in getting foreign bodies into the anterior chamber by using the Haab instrument. Dr. Pockley held that in modern hospitals there should be no delay of more than a few hours in the carrying out of an X-ray examination.

DR. KEITH COHEN spoke of his experiences during two and a half years at the Westminister Hospital. At this institution the Mellinger instrument was always used. The point in favour of the anterior route was the absence of any delay.

DR. E. D. D'OMBRAIN stated that he always used the posterior route.

Other opinions expressed were that the question of which route should be taken depended largely on the nature of the case under treatment.

Correspondence.

PUERPERAL PELVIC INFECTION.

SIR: The interest excited by speculations as to the cause and suggestions regarding treatment of puerperal pelvic infection is now widespread.

Though methods of treatment are diverse and results discouraging, there is great unanimity as to what may be accomplished by reorganizing the teaching.

While I agree that this is so, I am not satisfied that the teacher has revealed himself. Those who aspire to be teachers in the journals, drive me to the conclusion that it is from the ranks of the surgeons that we must recruit them. The surgeon has shown vastly improved results over pre-antiseptic days, the obstetrician has not. We cannot say that the fault lies with the latter unless he fails to acknowledge that antiseptics have their limitations. This is precisely what he has done! He says that what is good enough for the surgeon is good enough for him. He proceeds to eliminate the factor of recent contagion from a previous source by the use of antiseptics, each particular practitioner after his own fashion and with reagents whose strength is tempered to save his own par-

ticular skin. (He finds it necessary at times to contrive to save it in another way later!) He forgets the special liability of the lying-in woman to infection. The results of it are nearly always most serious, whereas it is more commonly a passing circumstance in general surgery. That is why the obstetrician is at a greater disadvantage than his self-satisfied *confère*. Then is applied the flattering unction—his environment militates against good results. But here statistics are against him. Environment, if we would only admit it, has no such baleful influence. The excuse goes down. He has saved his skin again and we find it a little thicker than it was before.

The obstetrician may exclaim against conclusions drawn from statistics. That they are not very reliable is shown in returns published by R. Dudfield in *The Lancet*, 1923, who easily exposes the figures to ridicule. It is most disturbing to discover in print what we all individually must acknowledge, that if the deaths from sepsis work out at 52.9% of the cases reported, there must be many cases not so reported as due to sepsis and a morbidity in addition reaching a much higher proportion than published figures show. Remembering that notification is comparatively a recent institution, figures prior to it are more likely to be a true reflex because the temptation to spoil one's averages by talking about them was accompanied by less compromising results. As things go then, we may expect the ridiculous mortality quoted by Dudfield to increase in the future.

Such admissions as we have that might reasonably be taken as a reflection on modern methods are qualified in a manner characteristic of all who make them as is shown in the following extracts:

"Someone has said that the dirt in the home of the very poor is dirt, while the dirt in the hospital is germs, and that is about as scientific a dismissal of the facts as can be made."

But why dismiss them so, are they not very significant and worth more than a passing sneer?

Then again:

"But even discounting all of that, there is the same factor of immunity if it can be so called, among the patients in slum districts which we mentioned above." (Eno, *Surgery, Gynecology and Obstetrics*, 1923)

Why avoid the issue by a qualification which ill-disguises the truth?

I will not weary your readers by quoting other examples, but I trust I have given a line for the future honest teacher fearlessly to follow.

Yours, etc.,

A. C. F. HALFORD, M.D. (Melb.).

Wickham terrace, Brisbane, July 19, 1924.

PYORRHŒA ALVEOLARIS.

SIR: Your timely and interesting article in this week's Journal (July 26, 1924) upon the much discussed subject of *pyorrhœa alveolaris* is welcome. It would seem that the day of moderate and well-balanced opinion upon this widespread and devastating oral disease is at last dawning and the era of the man who, on the one hand, refuses to believe that there is such a complaint as *pyorrhœa alveolaris* (or if there is, that it has no special significance), and of the one who, on the other hand, attributes to it every ailment from heartache to ingrowing toe-nails, is closing in and their voices will be heard less and less as time goes on. This is as it should be, for it can no longer be denied that the course of many chronic diseases or disease symptoms is profoundly affected by the presence of suppurating gums and alveolar processes; if, indeed, not actually caused thereby.

You comment in your article upon the fact that very few writers or speakers refer to the pathogenesis of the disease and also that methods of treatment and opinions upon prognosis are widely divergent. All this is lamentably true and there are many reasons for it, one of the most important being that up to the present the phase of the complaint upon which most attention has been concentrated, and which has been investigated and re-investigated without bringing us to any finality, is that of infection.

I would make bold to state that infection, serious though it is and ill-important to eliminate in treatment, is not the predominat factor in the genesis of the disease, but necessarily follows upon trauma and local lowered resistance. Thus, the great question resolves itself into not so much: "What this infection?" but "Why this infection?" So if we attack the problem of pyorrhœa from the standpoint of infection, as being the predominating feature in the picture, we are beginning at the wrong end and are foredoomed to failure.

Many attempts have been made to attach to some specific micro-organism the responsibility for the ætiology of pyrrohœa, but none of them has ever carried conviction. Of course, one would not deny that there are infections of the gingival tissues where specific micro-organisms have taken control, being of sufficient virulence to establish themselves and create their own environment and to dominate in it; such, for example, as the fuso-spirillary infection known commonly as "trench mouth." But these cannot be classed with pyorrhœa.

Looking beyond the actual infection then, we find many and varied factors at work in preparing the way for infection of the gingival and subgingival tissues. To name a few of these, we have mal-occlusion, non-occlusion, inability to obtain correct masticatory movements of the mandible owing to interference of cusps, peri-apical sepsis, ill-fitting crown bands, badly contoured fillings *et cetera* or of general causes, nephritis, diabetes, syhpilis, deficiency diet and so forth.

Starting now from this viewpoint, we have the key to successful treatment. To avoid taking up too much of your valuable space, I shall just enumerate the heads of what I consider to be the rational and logical line of treatment and moreover the line of treatment which experience has proved to yield most successful results:

(i.) Careful radiographic examination to determine the extent of the alveolar involvement and whether there is any concurrent periapical infection;

(ii.) Removal of hopelessly affected teeth, for example, (*a*) those where the bone destruction has progressed so far that the stability of the tooth is lost, (*b*) multi-rooted teeth where the infection has extended to the bone in the bifurcation, (*c*) teeth where there is an established peri-apical infection which cannot be cured by root treatment or by surgery. In reaching a decision as to the extraction or retention of any doubtful teeth, the dentist and physician should consult; because many time when retention may be possible from a dental point of view, it is distinctly inadvisable from the point of view of the physician.

(iii.) Adjustment of occlusal and masticatory relationships of the teeth and attention to crowns and fillings *et cetera;*

(iv.) Removal of visible and subgingival calculus and polishing of denuded root surfaces;

(v.) Eradication of remaining pockets by electric cautery or by surgery.

Yours, etc.,

E. STANLEY WALLACE.

"Whitehall," 215 Macquarie Street, Sydney.
July 30, 1923.

ANTERIOR METATARSALGIA.

SIR: I have for many years treated Morton's metatarsalgia as part and parcel of pathological flat foot and have seldom failed to obtain success. In the case referred by Dr. Royle, I cannot help thinking that if he had obtained full dorsi-flexion by dividing the deep plantar fascia and possibly lengthening the *tendo Achillis*, he would have obtained permanent relief. The inflamed bursa surely must be an additional symptom and not the cause.

Yours, etc.,

W. KENT HUGHES.

22, Collins Street, Melbourne,
July 5, 1924.

Proceedings of the Australian Medical Boards.

NEW SOUTH WALES.

THE undermentioned have been registered, under the provisions of the *Medical Act, 1912 and 1915*, as duly qualified medical practitioners:

BANCROFT, MABEL JOSEPHINE, M.B., 1924 (Univ. Sydney) Royal Prince Alfred Hospital.

BLAKEMORE, CONRAD GEORGE HOWELL, M.B., 1924 (Univ. Sydney), Cooper Street, Strathfield.

BROUGHTON, JOHN WALTER, M.B., Ch.M., 1924 (Univ. Sydney), Murdoch Street, Cremorne.

BULTEAU, ALFRED WILLIAM JAMES, M.B., Ch.M., 1924 (Univ. Sydney), 91 Lyons Road, Drummoyne.

CASTLEDEN, ELSIE MARION, M.B., 1924 (Univ. Sydney), Perkin Street, Newcastle.

CUTHBERT, GRACE JOHNSTON, M.B., Ch.M., 1924 (Univ. Sydney), Nelson Road, Lindfield.

EARLAM, MALCOLM SIDNEY STEWART, M.B., Ch.M., 1924 (Univ. Sydney), Royal Prince Alfred Hospital.

FURNESS, ALBERT STEPHEN, M.B., 1924 (Univ. Sydney), 28 Wolseley Road, Point Piper.

GEARIN, JOHN JOSEPH, M.B. (Univ. Sydney), 42 Allison Road, Randwick.

HOWES, JENNETTE KEITH, M.B., Ch.M., 1924 (Univ. Sydney), 5 Bradley Head, Mosman.

HUNTER, GEOFFREY THOMAS, M.B., 1924 (Univ. Sydney), Koyong, Forbes.

HURLEY, JOHN PATRICK GARVAN, M.B., Bac. Surg., 1916, (Univ. Melbourne), Corowa.

HURREY, HERBERT GRINDELL, M.B., Bac. Surg., 1914 (Univ. Melbourne), 659 New South Head Road, Rose Bay.

JAMES, GWILYM TALIESIN, M.B., Bac. Surg., 1920 (Univ. Melbourne), Lockhart.

JOHNSTON, LEONARD WALTER, M.B., Bac. Surg., 1918, (Univ. Melbourne), Morrow Street, Wagga.

LAIDLEY, JOHN WALWYN SHEPHEARD, M.B., Ch.M., 1924, (Univ. Sydney), Buckhurst Avenue, Double Bay.

LONGFIELD, STEPHEN ROBERT, M.B., Ch.M., 1924 (Univ. Sydney), 10 Dudley Street, Randwick.

MACKERRAS, IAN MURRAY, M.B., Ch.M., 1924 (Univ. Sydney), Stanton Road, Mosman.

MEACLE, NORMAN HARDING, M.B., Ch.M., 1924 (Univ. Sydney), 24 Lang Road, Centennial Park.

MORAN, HAROLD ELDON, M.B., Ch.M., 1924 (Univ. Sydney), Merrenburn Avenue, Naremburn.

OUTRIDGE, LESLIE MACDONALD, M.B., Ch.M., 1924 (Univ. Sydney), Redland Bay, Queensland.

PARK, WILFRED, M.B., 1924 (Univ. Sydney), Clarence Street, Burwood.

PEARSON, HENRY ROY, M.B., Ch.M., 1924 (Univ. Sydney), 10 Middleton Street, Stanmore.

RAINBOW, JAMES MANNING, M.B., Ch.M., 1924 (Univ. Sydney), Fairlight Street, Manly.

RALSTON, JOHN WINDEYER, M.B., Ch.M., 1924 (Univ. Sydney), First Avenue, Wentworthville.

RUTHERFORD, KEITH POWELL, M.B., Ch.M., 1924 (Univ. Sydney), McIntosh Street, Gordon.

SCOBIE, DEREK CAMPBELL, M.B., Ch.M., 1924 (Univ. Sydney), Queen's Road, New Lambton, Newcastle.

SMITH, CHARLES VANCE, M.B., Ch.M., 1924 (Univ. Sydney), 5 Hereford Street, Glebe Point.

STANDISH, WILLIAM ALEXANDER, M.B., Ch.M., 1924 (Univ. Sydney), 206 Victoria Street, Darlinghurst.

STEPHENS, JOHN GOWER, M.B., 1924 (Univ. Sydney), St. Andrew's College, Newtown.

STEVENSON, ROBERT BAYNTON COMRIE, M.B., Ch.M., 1924 (Univ. Sydney), Government Savings Bank, Darlinghurst.

STEWART, DOUGLAS MACDONALD, M.B., Ch.M., 1924 (Univ. Sydney), Wonga Street, Taree.

STREET, THOMAS RENDELL, M.B., Ch.M., 1924 (Univ. Sydney), 16 Forrest Road, Double Bay.

STUDDY, ALBERT STUART BRADRIDGE, M.B., Ch.M., 1924 (Univ. Sydney), Berry Street, North Sydney.

SWORD, DONALD CHARLES CAMERON, M.B., Ch.M., 1924 (Univ. Sydney), c.o. Union Trustee Co. of Australia, Ltd., Brisbane.

TEARNE, JOY DEBENHAM, M.B., 1924 (Univ. Sydney), Southwold, Mona Vale.

TRENERRY, FREDERICK, M.B., 1924 (Univ. Sydney), 11 George Street West, Sydney.

TUNLEY, LESLIE WILLIAM, M.B., 1924 (Univ. Sydney), Emily Street, South Brisbane.

UNDERWOOD, CECIL THOMAS, M.B., Ch.M., 1924 (Univ. Sydney), Market Street, Mudgee.

WOODS, LESLIE SAMUEL, M.B., Bac. Surg., 1920 (Univ. Melbourne), Albury.

WOOSTER, GORDON BRUCE ROY, M.B., Ch.M., 1924 (Univ. Sydney), 107 Wigram Street, Parramatta.

WORCH, HAROLD CHISHOLM, M.B., Bac. Surg., 1922 (Univ. Melbourne), Albury.

YELDHAM, ALAN EDWIN, M.B., Ch.M., 1924 (Univ. Sydney), Alfred Street, North Sydney.

Additional Registrations:

LIGGINS, WILLIAM FREDERICK LESLIE, Ch.M., 1924 (Univ. Sydney), Mungindi.

NELSON, WILLIAM THOMAS, M.R.C.P., 1923 London.

WALLACE, HUGH GILMOUR, D.P.H., 1923 (Univ. Melbourne), Newcastle.

Change of Name:

BYRNES, GODFREY JAMES, to BYRNE, GODFREY JAMES.

QUEENSLAND.

The undermentioned have been registered, under the provisions of the *Medical Act of 1867*, as duly qualified medical practitioners:

DERRICK, EDWARD HOLBROOK, M.D., 1922 (Univ. Melbourne), Brisbane.

HALL, THOMAS MERVYN SEYDE, M.B., 1924 (Univ. Sydney), Mount Mulligan.

PAINE, CLIVE LANSDELL, M.B., Ch.M., 1920 (Univ. Sydney), Atherton.

RICHARDS, REGINALD ERNEST, M.B., B.S., 1922 (Univ. Melbourne), Rockhampton.

WILLIAMS, DARCY AMBROSE, M.B., Ch.M., 1923 (Univ. Sydney), Brisbane.

TASMANIA.

The undermentioned have been registered, under the provisions of *The Medical Act, 1918*, as duly qualified medical practitioners:

LEHMAN, SIDNEY JAMES, M.B., B.S., 1923 (Univ. Melbourne), Hamilton.

MCINNES, ALFRED LOTHIAN, M.B., B.S., 1924 (Univ. Melbourne), New Norfolk.

SANDFORD, ELMA LINTON (now ELMA LINTON MORGAN), M.B., Ch.M., 1917 (Univ. Sydney), Hobart.

Naval and Military.

APPOINTMENTS.

The following appointments, changes *et cetera* have been promulgated in *Commonwealth of Australia Gazette*, No. 35 and 39, of June 5 and 19, 1924:

Citizen Naval Forces of the Commonwealth.

Royal Australian Naval Reserve (Sea-Going).

Promotion.—SURGEON-LIEUTENANT HAROLD HENRY FIELD-MARTELL is promoted to the rank of Surgeon Lieutenant-Commander, dated March 1, 1924.

Resignation.—The resignation of ALAN SYME JOHNSON, M.B., of his appointment as Surgeon-Lieutenant (Retired List) is accepted, dated April 26, 1924.

Australian Military Forces.

FIRST MILITARY DISTRICT.

Australian Army Medical Corps.

The provisional rank of CAPTAIN H. EVANS is confirmed.

Australian Army Medical Corps Reserve.

HONORARY CAPTAIN F. S. THOMAS is transferred to the Australian Army Medical Corps Reserve, 5th Military District, May 20, 1924.

SECOND MILITARY DISTRICT.

Award of the Colonial Auxiliary Forces Officers' Decorations

Australian Army Medical Corps.—LIEUTENANT-COLONEL W. C. GREY.

THIRD MILITARY DISTRICT.

Australian Army Medical Corps.

To be Lieutenant (provisionally)—KENNETH HOWARD HADLEY, May 10, 1924; the provisional rank of CAPTAIN H. L. STOKES is confirmed; CAPTAIN F. L. APPERLY is transferred to the Reserve of Officers, May 1, 1924.

To be Lieutenant (provisionally)—GEOFFREY ALFRED PENINGTON, May 20, 1924.

To be Majors.—CAPTAINS A. V. R. HANSEN and R. C. WITHINGTON; CAPTAIN (Temporary Major) M. J. HOLMES, D.S.O. (provisionally); CAPTAINS W. W. S. JOHNSTON, D.S.O., M.C., T. G. S. LEARY, H. C. DISHER, P. A. STEVENS, and C. R. MERRILLEES, May 1, 1924. MAJOR J. K. ADEY, O.B.E., is transferred from the Unattached List, and to be super-numerary to the establishment of Majors, with pay and allowances of Captain, May 10, 1924.

Australian Army Medical Corps Reserve.

To be Honorary Captain.—BRIAN ROSSE WOODS, May 20, 1924.

Awards of the Colonial Auxiliary Forces Officers' Decoration.

Australian Army Medical Corps.—COLONEL R. M. DOWNES, C.M.G.

FIFTH MILITARY DISTRICT.

Australian Army Medical Corps Reserve.

HONORARY CAPTAIN F. S. THOMAS is transferred from the Australian Army Medical Corps Reserve, 1st Military District, May 20, 1924.

Medical Appointments.

DR. H. MCCARTNEY DE BURGH (B.M.A.) has been authorized by the Board of Health of New South Wales as an Inspector under the *Cattle Slaughtering and Diseased Animals and Meat Act, 1902.*

Medical Appointments Vacant, etc.

FOR announcements of medical appointments vacant, assistants, *locum tenentes* sought, etc., see "Advertiser," page xvi..

UNIVERSITY OF OTAGO: Professor of Surgery.

Medical Appointments: Important Notice.

MEDICAL practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429, Strand, London, W.C..

BRANCH.	APPOINTMENTS.
NEW SOUTH WALES: Honorary Secretary, 30 - 34, Elizabeth Street, Sydney.	Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phœnix Mutual Provident Society.
VICTORIA: Honorary Secretary, Medical Society Hall, East Melbourne.	All Institutes or Medical Dispensaries. Australian Prudential Association Proprietary, Limited Mutual National Provident Club. National Provident Association.
QUEENSLAND: Honorary Secretary, B. M. A. Building, Adelaide Street, Brisbane.	Brisbane United Friendly Society Institute. Stannary Hills Hospital.
SOUTH AUSTRALIA: Honorary Secretary, 12, North Terrace, Adelaide.	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIA: Honorary Secretary, Saint George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW ZEALAND (WELLINGTON DIVISION): Honorary Secretary, Wellington.	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

AUG. 19.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
AUG. 19.—Illawarra Suburbs Medical Association, New South Wales.
AUG. 20.—Western Australian Branch, B.M.A.: Council.
AUG. 22.—Queensland Branch, B.M.A.: Council.
AUG. 26.—New South Wales Branch, B.M.A.: Medical Politics Committee; Organization and Science Committee.
AUG. 27.—Victorian Branch, B.M.A.: Council.
AUG. 28.—New South Wales Branch, B.M.A.: Branch.
AUG. 28.—South Australian Branch, B.M.A.: Branch.
AUG. 31.—Victorian Branch, B.M.A.: Notice *re* Election.
SEP. 3.—Victorian Branch, B.M.A.: Branch.
SEP. 5.—Queensland Branch, B.M.A.: Branch.
SEP. 9.—New South Wales Branch, B.M.A.: Ethics Committee.
SEP. 10.—Tasmanian Branch, B.M.A.: Branch.
SEP. 10.—Central Northern Medical Association, New South Wales.
SEP. 10.—Melbourne Pædiatric Society.
SEP. 11.—New South Wales Branch, B.M.A.: Clinical Meeting.
SEP. 11.—Victorian Branch, B.M.A.: Council.
SEP. 11.—South Australian Branch, B.M.A.: Council.
SEP. 11.—Brisbane Hospital for Sick Children: Clinical Meeting.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

All communications should be addressed to "The Editor," THE MEDICAL JOURNAL OF AUSTRALIA, B.M.A. Building, 30-34, Elizabeth Street, Sydney. (Telephone: B. 4635.)

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